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</td>
<td>Lincolnshire</td>
</tr>
</tbody>
</table>
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. Across the four main hospitals (Boston, Grantham, Lincoln and Louth) and three (Gainsborough, Skegness and Spalding), ancillary sites where some services are delivered, the trust provide a comprehensive range of hospital based medical, surgical, paediatric, obstetric and gynaecological services to over 700,000 people in Lincolnshire. In an average year, the trust treat more than 145,000 accident and emergency patients, nearly half a million outpatients and almost 100,000 inpatients.

The trust has 942 inpatient beds, 76 day-case beds and 87 acute children’s beds across 48 wards, operates 2275 outpatient clinics per week and employs approximately 8,500 staff. It is one of the largest acute NHS trusts in England.

The national, regional and local context:
The context within which the trust deliver services includes:

- Lincolnshire is the second largest county in England and currently ranks 18th in terms of the overall population. However, it has a very low population density of just 155 people per square kilometre.
- As a rural county with an extensive coastline, the population is subject to seasonal fluctuations caused by holidaymakers. This puts further stress on services that are in places already stretched.
- The population is currently increasing faster than the rest of the East Midlands or the national average and is predicted to grow by 16% within the next 20 years.
- There are some areas of Lincolnshire that are ranked amongst the most deprived in the country, and others that are ranked amongst the least deprived.
- There is a declining younger population and a growing older population, which not only changes the needs of patients but also the frequency of medical consultation required.
- Public transport in Lincolnshire can be restrictive on people’s ability to attend major hospitals.
- The infant mortality rate in Lincolnshire is 3.2 deaths per 1,000 live births, which is lower than both the East Midlands and English averages.

**Patient numbers**
Each year the trust sees within the region of

- 1,021,137 outpatient attendances
- 134,102 inpatient admissions
- 32,967 planned elective surgical cases
- 147,875 attendances at the accident and emergency department
- 4,702 babies born

(Source: Hospital Episodes Statistics March 2018 – February 2019)

**Financial position**
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.

For 2018/19 the NHS trust did not achieve its control total of £74.7 million deficit excluding Provider Sustainability Fund (PSF) and £54.5 million deficit inclusive of PSF. The NHS trust revised its forecast early in 2018/19 to £89.4 million deficit but reported a better position of £88.2 million deficit excluding PSF on a turnover of £447 million (19.7%) at the end of the year.

In 2018/19, the NHS trust underperformed against its cost improvement plan, achieving only £18.89 million (3.39% of expenditure) against a plan of £27.6 million plan (5.08% of expenditure). The NHS trust did not have in place the infrastructure required to ensure implementation of initiatives, tracking of benefits and management of delivery risks. This resulted into substantial slippages early in the year, triggering the reforecast. Because of this and other workforce cost pressures, the NHS trust pay expenditure exceeded budget by £17.8 million (5.5%).

What people who use the trust’s services say

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 consistently below the England average for recommending the trust as a place to receive care from April 2018 to March 2019.

Inpatient Survey
This survey looked at the experiences of 76,668 people who were discharged from an NHS acute hospital in July 2018.

Between August 2018 and January 2019, a questionnaire was sent to 1,250 recent inpatients at each trust.

Responses were received from 539 patients at United Lincolnshire Hospitals NHS Trust.

United Lincolnshire Hospitals NHS Trust scored about the same as other trusts for 58/63 questions in the 2018 Inpatient survey.

There were five questions that were worse when compared with other trusts. These were:

- Support after discharge 5.8/10
- Care after discharge 6.1/10
- Purpose of medicines 7.7/10
- Taking part in research 0.7/10
- Patients' views 0.6/10

Children and young people
This survey looked at the experiences of 34,708 children and young people who received inpatient or day case care during October, November and December 2016.

Between February and June 2017, a questionnaire was sent to a maximum of 1,250 recent patients at each trust.

Responses were received from 294 patients at United Lincolnshire Hospitals NHS Trust.

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.

Maternity Survey
During the summer of 2018, a questionnaire was sent to all women who gave birth in February 2018 (and January 2018 at smaller trusts).
Responses were received from 143 patients at United Lincolnshire Hospitals NHS Trust.

United Lincolnshire Hospitals NHS Trust scored about the same as other trusts for all questions in the 2018 maternity survey.

**Cancer Patient Experience Survey 2017**

In the Cancer Patient Experience Survey 2017, the trust scored worse than the national average for 55/63 questions and the same as the national average for 3/63 questions. The trust scored better than the national average for 5/63 questions, these were:

- Patient told they could bring a family member or friend when first told they had cancer
- Groups of doctors or nurses did not talk in front of patient as if they were not there
- Staff told patient who to contact if worried post discharge
- Beforehand patient had all information needed about radiotherapy treatment
- Patient given understandable information about whether radiotherapy was working

**PLACE**

In the Patient-Led Assessments of the Care Environment (PLACE) 2017 the trust was below the national average on all measures. At site-level all four sites were below the national average for all measures except food (Lincoln County and Louth).
Is this organisation well-led?

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.

Leadership

Not all leaders had the skills and abilities to run the service. Not all leaders understood and managed the priorities and issues the services faced. However, most leaders supported staff to develop their skills and take on more senior roles. They were visible and approachable in the service for patients and staff. Leaders had integrity.

Board Members

Of the executive board members at the trust, 0% were Black and Minority Ethnic (BME) and 12.5% were female.

Of the non-executive board members 0% were BME and 57.1% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>57.1%</td>
</tr>
<tr>
<td>All board members</td>
<td>0%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

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

There was a lack of diversity amongst board members. However, the board was not significantly different to the local population with the largest population in Lincolnshire county as White: British/English/Scottish/Northern Irish/Welsh at 93%. However, during our inspection we noted an exceptionally high proportion of BME medical staff; yet there was minimal BME medical leadership across the trust.

Not all executive directors had the skills, knowledge and experience to lead the trust and there had been some changes to personnel and roles taking place since our last inspection (April 2018). The board and organisational leadership were going through a period of transition. Non-executive directors had a mix of NHS experience and non-NHS experience. The executive team were a mix of substantive and acting appointments. The chief executive was newly appointed having started in their role at the trust in July 2019, the director of finance was in an acting role and the director of nursing was working out their notice period.

The chair had significant public sector and NHS experience (30 years). They had previously chaired a neighbouring community NHS trust.

The chief executive had been in post only two weeks at the time of the well led review. They were previously chief executive of a neighbouring community NHS trust. They had held chief executive roles in the NHS since 2004. The chief executive was able to describe their key priorities and vision for the trust.

The acting director of finance and procurement had been at the trust for 18 months. Previously as deputy director of finance and in the acting director of finance role for less than one year. The acting director role was their first executive position. The acting director of finance and procurement was supported by an interim [Senior Financial Advisor] who led on development and
delivery of the trust’s financial efficiency programme (FEP) and delivery of financial improvement plans. The wider finance team had also been supported by external consultants focussed on financial improvement since 2017. However, this consultancy support was being phased out.

There was stability in the rest of the finance team with marginal vacancies, however stakeholders indicated that investment was required to enhance the capability and capacity within the finance business partner team, to better meet the business needs.

At our last inspection 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 required urgent improvement at the trust limited the capacity of the executive team to sustainably address these issues at pace. At this inspection we found whilst the executive leadership team demonstrated to us a knowledge of current priorities and challenges they did not always get delivered due to capacity and capability. During our interviews with individual members of the executive leadership team we were consistently told there was a need to continue building internal capability (within divisions) to drive improvements.

The trust board was a ‘unitary’ board of non-executive directors and executive directors who had collective responsibility for all aspects of the performance and business of the trust, including quality and safety and clinical and financial performance. The trust board comprised of 11 voting members, the chief executive, chair, five Non-Executive Directors (NEDs) and eight executive directors. Non-executive directors are not full-time employees of the trust. They help to ensure the trust is accountable to the people it serves. They are people who live or work in the area and have shown an interest in the provision of health services for the local people.

The trust board members and NEDs we met were a group of individuals with a wide range of experience, knowledge and skills. Board development sessions took place monthly to ensure that skills were maintained and developed. The development session agenda was driven by an annual programme. A key priority for the board development sessions was to develop a unitary board with the trust board in agreement on the direction of travel for the trust.

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 all five 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. The NEDs described to us a good working relationship with the executive directors and told us this relationship had been strengthened through the direction of the chair.

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 the organisation faced, we raised issues that had been found on the core service inspection where their oversight was insufficient. For example, concerns in relation to the emergency department at Lincoln County Hospital and governance in children and young people services. When we had previously pointed out issues at Pilgrim Hospital’s emergency department which had resulted in imposing of section 31 conditions in 2018, the trust responded urgently with clear and detailed action plans. The board had developed a number of requirement notices in relation to children and young people, at this inspection we found a number of the breaches we identified had not been addressed sufficiently. We subsequently issued a section 29a warning notice. The trust oversight of the
quality improvement plan for these areas had lacked the pace at which change was required and we did not see sufficient evidence on how this was being monitored.

The board had a good understanding of the financial position of the trust. The chair, the non-executive chair of the performance, finance and resources (PFR) committee and executive members of the board attended quarterly review meetings with NHS England and Improvement and demonstrated understanding of the trust’s financial challenges. Board members were sighted on key financial efficiency programmes and on the overall financial position of the trust.

Workforce and staffing issues were the trust’s largest risk from a financial, quality and service continuity perspective. Leadership on addressing workforce issues had previously been provided by the HR team, with limited ownership of improvement plans at divisional level. At this inspection senior managers told us divisions have all taken responsibility for addressing issues identified in the 2018 staff survey. In addition, significant work had been undertaken by divisions to address the issues that were important to their staff and areas.

The board ambition was to raise the quality of leadership at all levels within the trust. The trust had implemented a new operating model with four divisions. Appointments have been made to most divisional leadership roles, but there remained some gaps. Executive directors were promoting a more devolved style of organisational leadership through the new operating model. This was in transition and had not yet embedded and there were some leadership gaps in the organisation.

At our last inspection 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. At the time of our last 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. There had been some slippage to this timeline and the trust had implemented a new management structure known as the trust operating model (TOM) on 1 April 2019, two months prior to our core service inspection. The trust operating model was divided into four divisions with a number of specialities (13 in total) aligned to each division. Each division was managed by a triumvirate which consisted of a divisional director, divisional manager and divisional nurse/midwife. At the time of our inspection not all posts had been filled substantively. Each speciality was supported by a head of service, lead nurse and matron. During this inspection we found, improvements had been made to the divisional leadership structures which better support financial improvement. However, leadership structures needed a continued focus to ensure they embedded across the organisation.

Staff had previously indicated significant concerns regarding leadership at the trust which had resulted in one vote of no confidence in the board and a number of votes against individuals on the board. The leadership team had a difficult relationship with staff unions.

Throughout our core service inspections and staff focus groups, most staff we spoke with raised concerns about the new TOMs. Staff raised concerns about the lack of visibility of the new senior management teams and some staff were unaware of who the leadership team were. However, all staff recognised the trust were in the early stages of this leadership model and therefore felt unable to comment on how the TOM would improve services. The executive team saw the introduction of the TOM as a positive move with executives now having time to work more strategically, with the TOM having more of an operational focus.

We held a focus group for divisional leads during our well led inspection and seven attended. All spoke positively about the new TOM and felt it would afford consistency across divisions and hospital sites. However, all recognised the model was in its infancy with some divisions further ahead than others. We were told in some divisions they were still in the process of establishing roles of responsibilities and recruiting staff to the roles supporting the senior team and systems and processes in place to address issues and challenges within the services had not yet been
established. Some divisional leads did not feel fully engaged in decisions about financial improvement and told us they had little or no oversight of their divisional budgets.

The chief pharmacist understood the challenges to quality and sustainability and could identify the actions needed to address them.

The trust had a senior leadership forum on a six-weekly basis for all senior leaders to work collectively on significant issues facing the organisation.

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 carried out in maternity and pharmacy.

There was a programme of board visits to services / ward. Undertaken by an executive and NED, visits were weekly to individual areas. NEDs told us visits helped gain an understanding of what the pressures were like for frontline staff. However, we were not assured visits consistently took place. For example, for quarter one (April to June 2019), information provided by the trust showed visits had taken place in six out of 13 weeks.

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 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.

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 access to all programmes.

The trust offered short workshops in topics including appraisal, recruitment and selection, core leadership behaviours, difficult conversations, leading and managing teams. Staff could access these as stand-alone workshops so they could target those that were most appropriate for them. In addition, the trust offered values based development centres where staff worked through a number of observed and assessed exercises and then received detailed feedback on their strengths and development needs with signposting to appropriate learning opportunities.

The trust were accredited with system partners to run the National Leadership Academy Mary Seacole Local programme and almost 50 ULHT staff had completed or were currently taking part in the programme.

Within pharmacy services we saw clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and there was a leadership strategy or development programme, which included succession planning. Senior managers told us they recognised where individuals strengths were. The pharmacy team was described as a ‘flat structure’ below the chief pharmacist. The chief pharmacist was supported by a deputy chief pharmacist and site leads. Staff were encouraged to contribute to service development through a non-hierarchical structure. The deputy chief pharmacist had been through a chief pharmacist development pharmacist programme. The chief pharmacist was exploring creating two associate chief pharmacist posts to develop and ensure expertise in development of service delivery.

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 further improvements in the knowledge and management of patents presenting to the trust living with dementia, learning disabilities or a mental health condition since our last inspection.
Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, not all leaders and staff understood and knew how to apply them and monitor progress.

The trust had developed and communicated a trust strategy known as ‘2021’. This set out the vision, outcomes and strategies for the organisation. The 2021 strategy had been reviewed against ‘True North’ priorities and aligned to system plans. ‘True North’ priorities are a set of short-term priorities for the trust to deliver. The trust was also developing a five-year ‘Journey to Excellence’ long term plan.

The trust had established a vision and ambitions for the trust, underpinned by the values and expected behaviours outlined in their 2021 strategy. The strategy set out priorities and objectives for delivery, aligned to their performance framework and board assurance framework. The strategy reflected the wider system approach to improving health and social care across Lincolnshire. The strategy was aligned 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.

The trust had also established strategic transformational improvement programmes of delivery, monitored and managed through the 2021 programme board governance mechanisms.

The vision: Excellence in Rural Healthcare

Ambitions

- 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
- Our Partners: Providing seamless integrated care with our partners

Values

- Patient Centred
- Safety
- Compassion
- Respect
- Excellence

The trust had been reviewing their delivery model since 2017 and working on the implementation of the new Trust Operating Model throughout 2018, to facilitate the delivery of the 2021 strategy through clear governance supported by the delegation of authority and decision-making to division, including devolution through earned autonomy.

The 2021 strategy had two key parts - "Striving for Excellence", which set the strategic direction with the ambitions and the key enabling strategies, and the "Delivering Excellence" part which set out the programmes of improvement being managed by the programme management office. These were both underpinned by the values and the behaviours which were further supported through the staff charter.

The vision, ambitions and the improvement programmes had been developed through staff, patient and stakeholder engagement, there had been various events to capture the feedback including:

- Visiting 57 public and patient groups across Lincolnshire, hosting public member’s locality forums meetings listening to over 1,070 patients and public.
- Received 805 responses to the trust’s 2021 survey, made up of both public and staff, and over 200 responses from the senior leadership forum.
Conducted a 2021 staff engagement event which was attended by 193 members of staff, with an additional 260 people reached through email polls and engagement of thousands of people through social media.  

A staff ideas board had generated in excess of 200 different suggestions and ideas.  

The trust strategy had a number of improvement programmes within it. These included:

- Improving quality and safety  
- Saving money and improving our environment  
- Redesigning our clinical services  
- Delivering productive services  
- Developing the workforce to meet future needs  

The trust had set out priorities to take forward the ambitions. The priorities were aligned to patients, services, people and partners and can be seen below:

**Patients**  
- Harm free care  
- Valuing patient’s time

**Services**  
- Zero waiting  
- Sustainable services

**People**  
- Modern & progressive workforce  
- One Team

**Partners**  
- Service Integration

In order to make progress towards the strategy, vision and ambition the trust was working in partnership across the STP and further afield with organisations within the East Midlands. The trust was planning to deliver productivity gains to enable it to meet the requirements for demand for services while mindful of the resources available. The trust was reviewing key services to understand the risks and opportunities with each one and looking, as part of the service review programme, to understand the fragility and resilience of each service. A key objective of this partnership working was to see if the trust could be supported by other NHS partners to deliver models such as 'Hub and Spoke' which would be led by other NHS organisations and centralisation of some services at single sites.

During this inspection we were not assured the strategy was robust or realistic for achieving the trust’s priorities and delivering good quality sustainable care. Throughout our core service and well led inspections we found; staff did not always understand how their role contributed to achieving the strategy. In addition, as was the case at our last inspection, the trust continued to have the same competing priorities with little or no time to reflect upon transformational change.

Senior leaders told us they had the talent within the organisation to realise the trust objectives however, recognised a significant amount of work was required to encourage, develop and empower staff to take ownership for the future of the organisation.  

There was some progress against delivery of the strategy and local plans were monitored and reviewed, and we saw evidence to show this. However, progress was slow and improvements in their infancy. Whilst it was clear there was a collective understanding of the ongoing pressures the organisation was facing there appeared to be an air of normalisation with some of the executive team regarding past and current challenges.
Delivery of the trust’s strategic ambitions was monitored and managed through the 2021 programme governance. The 2021 programme board met monthly, monitoring the highlights, managing by exception and risks to delivery. This was supported by the 2021 programme hub.

Each of the improvement programmes had supporting programme groups, which monitored and managed the delivery of the objectives and activities of each of the programmes of work.

There were regular update reports to the trust board committees for assurance against delivery, together with updates to the trust board.

There had been progress through:

- Our Patients: Quality improvement plan, quality strategy and the research strategy.
- Our Services: Implementing the trust operating model, Getting It Right First Time (GIRFT), service reviews, clinical strategy, finance strategy, digital strategy, estates and environment strategy.
- Our People: People strategy, inclusion strategy and organisational development plan, leadership development, talent academy, quality improvement programme and FAB Ambassadors.
- Our Partners: Integration of the STP into the clinical strategy.

The trust had a refreshed meetings schedule in line with supporting the decision-making governance for the new TOMS which it hoped would further mature the monitoring against delivery of the ambitions, through realigning the reporting of the strategy and vision. At the time of our inspection there was further reporting being developed to ensure alignment with the strategic objectives, strategic priorities and tactical priorities, together with strengthening divisional reporting and ownership through the new ways of working.

The patient and carer experience strategy was under review at the time of our inspection. The new strategy to be known as a plan was to be discussed at the patient experience group and quality governance committee scheduled following our inspection. It was for final board approval in August 2019.

The trust did not have an up to date estates strategy at the time of our inspection. An external company had been engaged to undertake a piece of work to look at the impact of site reconfiguration which aligned to the local STP and acute service reconfiguration. The trust expected a strategy to be in place by autumn 2019.

Culture

Staff did not always feel respected, supported and valued and were not always focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work but did not always provide opportunities for career development. The trust had an open culture where patients and their families could raise concerns without fear. However, there was not effective processes in place to provide an open culture where staff could raise concerns without fear.

During our core service inspection we found there were low levels of staff satisfaction in the trust and high numbers of staff feeling overworked. Senior managers and board members recognised this and told us that culture within the organisation was one of their key priorities.

There were significant cultural issues at the trust related to its rurality and multi-site model which sometimes resulted in variations in culture and a limited sense of a unified trust. The board had acted to try to address this through the creation of the new operating model, this had not yet embedded and there was limited evidence to demonstrate substantive change in culture to date. The new operating model had brought in some new divisional leaders who could facilitate cultural change together with the new chief executive.

The trust had taken a number of actions to address concerns regarding inclusivity including: development of a staff charter which included personal responsibility; promotion of staff networks to address equality issues; senior leadership forums; and ‘Big Conversations’.
The Board were taking steps to promote devolved decision making and responsibility to move away from a reactive culture with high dependence on executive directors. The design of this was under development.

The trust continued to face considerable challenge in embedding and sustaining a culture of high quality sustainable care due to its reliance on temporary staff. We found areas during our core service inspection and during our focus groups of care which fell short of the trust values. There was a mix in the number of staff in the trust who could articulate and were demonstrating the values of the organisation. Culture varied on each site and there was an even split in the number of staff who reported feeling unsupported, respected and valued. The culture amongst staff at this inspection had declined since our last inspection, staff appeared less engaged.

Due to the number of 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.

Pharmacy staff told us not there was not enough time on the wards to do a full job and we saw evidence of an error not being picked up for nine days. Senior managers within this service agreed ward based services were lacking. Staff felt the message was not well received or understood by the executive team and felt the trust was slow to respond, owing in part to financial pressures in other areas which took priority. In addition, staff felt when risks were highlighted to the executive team, they were not always taken seriously and had been told "your risk may be 20 but there are other risks of 20 that are more serious" or "well, there has been no harm". Staff felt they were not always being listened to and risks could get buried.

The board was responsible for ensuring that there was safe staffing levels in clinical areas with delegated responsibility to the director of nursing (DoN) for nurse staffing levels. Twice a year, a board paper was presented in accordance with National Quality Board (NQB) and NHSI requirements, that summarised the nursing establishment reviews with recommendations and since our last inspection, demonstrated where quality impact assessments had also been undertaken to support changes to skill mix and staffing numbers. The establishment reviews were undertaken by the DoN and deputy chief nurse in the summer (light touch review) and in the autumn (full review) and fed into the trust financial planning process that would need to support any changes. The confirm and challenge meetings included the head of nursing, matron and ward manager. National tools such as Safer Care Nursing Tool, RCM paediatric standards, Birthrate Plus, BAPM, NHSI safe staffing guides and NICE Quality Standards as well as professional judgement were considered as part of the staffing reviews.

To provide objectivity for midwifery staffing levels, an external Birthrate Plus assessment was commissioned in 2017. In 2018, the monthly staffing publications were also changed to include CHPPD as per NHSI and NQB requirements, these were also compared at a national and peer group level through the bi-annual establishment reviews using Model Hospital support. CHPPD is a simple calculation by dividing the number of actual nursing (both registered and unregistered) hours by the number of patients. CHPPD is one part of the nursing workforce component of the model hospital.

Fill rates and CHPPD were collected and uploaded monthly to UNIFY as per national policy. Fill rates by site were sent daily to the senior nursing team which was broken down by substantive, bank and agency fill rates. Fill rates were published on the ward’s quality and safety board’s daily so visible to patients and were available for staff through the electronic SafeCare system in real time. Fill rates and CHPPD were also reported to board monthly in the nursing and midwifery workforce paper. Staffing levels were triangulated with quality and safety on a monthly basis through the ward health check.

There were standard operating procedures in place to assist operational nurse managers in managing staffing levels on a daily basis, including requesting bank and agency and red flag escalation processes. This also included moving staff across the sites to ensure that the balance between substantive and temporary staffing was maintained.
Agency reduction plans were included in the trust financial recovery plan and recruitment and retention processes. At the time of our well led inspection, the trust was running at an 18% nurse vacancy rate. Developing the workforce to meet future needs was identified as one of five improvement programmes within the trust strategy. To address the shortfall in the nursing workforce a programme of international recruitment was planned however, the business case for this recruitment programme was yet to be approved this meant, the trust, in the shorter term, was unlikely to realise a significant impact on nurse staff vacancy levels across the trust.

At our last inspection we saw a significant improvement in the numbers of consultants who had job plans reviewed. At this inspection we were not assured the previous focus in this area had been sustained. We received mixed messages from executive directors regarding job planning with some describing the process as “better” and some as “not having our full attention”. Information received following this inspection showed, out of 488 consultants and specialty doctors, the trust had 255 (52%) who had an agreed job plan (agreed between themselves and their clinical lead) and 82 (17%) of the 255 had been formally signed off by the Consistency Checking Panel. This was worse than the previous year. We reviewed the trust board meeting minutes for August 2019, we saw the board did not receive assurance that up to date job plans were in place, the board were advised there had been delays in the process. The board was advised reviewed job plans would be in place before the end of 2019.

The trust was a regular reporter to the National Reporting Learning System (NRRLS) and took significantly less time than other trusts to report patient safety incidents. The median time taken to report incidents was three days for this organisation compared to 30 for all trusts (April 2018 to September 2018). When compared with all other trusts this organisation was in the middle 50% of reporters. In the year from June 2018 to May 2019 there were roughly 1,000 patient safety incidents per month that were reported to NRRLS, this was similar to the previous year. However, NRRLS had identified a downward trend in reporting patient safety incidents resulting in death or severe harm suggesting a potential under-reporting of these incidents. During our core service inspections, most staff told us they were encouraged to report incidents and most staff received feedback from incidents raised. Some staff were able to give examples of shared learning from incidents that had occurred elsewhere in the trust.

During our inspection we received information from the Health and Safety Executive. They had written to the trust citing concerns about delays in reporting RIDDOR. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These Regulations require employers, the self-employed and those in control of premises to report specified workplace incidents. Over the preceding 12 months a significant number of the reports made under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 had been received outside the statutory reporting requirement of 15 days. In some cases, reports were received several months after the incident had occurred. The information concluded the roles and responsibilities of staff needed to be reviewed in order to ensure timely reporting.

Staff Diversity

The trust provided the following breakdowns of staff groups by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Qualified nursing and health visiting staff (%)</th>
<th>Qualified nursing midwifery staff (%)</th>
<th>Qualified allied health professionals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>29.7%</td>
<td>91.3%</td>
<td>98.8%</td>
<td>87.9%</td>
</tr>
<tr>
<td>BME – British</td>
<td>39.5%</td>
<td>5.7%</td>
<td>0.4%</td>
<td>2.4%</td>
</tr>
<tr>
<td>BME – non-British</td>
<td>22.8%</td>
<td>2.4%</td>
<td>0.8%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Unknown / not stated</td>
<td>8.0%</td>
<td>0.6%</td>
<td>N/A</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity tab)
NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.

The trust’s 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Equality, diversion and inclusion
- Health and wellbeing
- Quality of care
- Safe environment – bullying and harassment
- Staff engagement

There were no themes where the trust’s scores were significantly higher (better) when compared to the 2017 staff survey.

(Source: NHS Staff Survey 2018)

The trust did not have a specific staff survey action plan, as they told us results of the staff survey formed part of the people strategy.

The response rate to the 2018 national staff survey was above the national average, indicating a willingness of staff to engage with the trust. There had been an increase in the number of staff saying that the trust’s values were discussed as part of their appraisal (from 24.6% in 2017 to 33% in 2018 against a national average of 35.1%) and an improvement in four of the six scores.
around safety culture. However, the trust had seen a significant fall in the number of staff who would recommend the trust as a place to work. This peaked at 54.9% in 2016 and was now 41.4%, against an average of 62.6%, indicating a significant issue around staff morale. In addition, the staff engagement score had dropped from 6.6 to 6.5 (national average of 7.0).

Themes were consistent with the 2017 staff survey. Senior leaders felt morale was being impacted by the significant challenges the trust was facing. Each of the new divisions was to receive their own set of results and senior leaders were to work with them to engage staff in identifying priority actions they might take.

**Workforce race equality standard**

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.
As of 2018, one of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

2. In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (11.7% of BME staff compared to 19.4% of White staff). This has decreased by 1.5% compared to the previous year, 2017, although this was not a statistically significant change over time.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicator showed a statistically significant difference in score between White and BME staff:

8. 19.1% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey) which was significantly higher when compared to 8.5% of White staff. The score had increased by 3.0% when compared to the previous year, 2017, however this was not a statistically significant change over time.

(Source: NHS Staff Survey 2018; NHS England)

The trust LGBT and staff network had recently drafted a three year plan of work to improve the experience of LGBT patients and service users, as well as staff. This was to include the publication of a policy for trans patients and staff, as well as supporting the trust in implementing the NHSE Sexual Orientation Monitoring Standard. A BAME staff network led on work around the WRES and was starting to articulate a wider vision beyond the WRES.
Throughout the core service and well led inspections we did not see enough evidence of how staff from a BAME background were being supported through their career development. The causes of workforce inequality had not been sufficiently addressed. Non-executive directors recognised there was little or no evidence to suggest BAME group initiatives were working to address workforce inequalities. Similarly, the chief executive told us there was work to do to develop BAME leadership development and the equality and diversity agenda.

**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 consistently below the England average for recommending the trust as a place to receive care from April 2018 to March 2019.

![Graph showing Friends and Family Test scores](image)

(Source: Friends and Family Test)

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, this was the same at our last inspection.

The trust had seen the number of contacts with the FTSUG increase. The trust had appointed a permanent deputy trust secretary to allow the FTSUG to give ring fenced time to supporting staff who need to speak up, however the time allocated was not sufficient for an organisation of this size. At the time of this inspection one day a week ‘protected time’ was afforded to the FTSUG.

The FTSUG continued to have monthly 1:1 meetings with the Chief Executive. The Chief Executive (retired now) had been concerned that staff did not feel safe to speak up and had challenged the FTSUG to further promote with all staff the ways in which this could be done. The
trust board report for February 2019 stated a communication package to encourage staff to act as FTSU Champions was in draft and would be rolled out during February. The trust also planned to build a network of staff who could act as a front line contact point across all sites.

At our well led inspection executive leads told us the trust was in the process of establishing a network of FTSUG champions. We were told staff had been consulted as to what the network should look like, for example, site or division based. As a result of the consultation, nine volunteers had come forward so far. The trust was aiming for 15 in total. Additional plans included regionally delivered training and regular champions meetings. Staff during our core service inspection and during our focus groups were not aware of a communication package or the plans to build a network.

Information on FTSUG was given to staff at their induction. Posters were displayed around the trust and the trust was embarking on a new publicity campaign.

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 2018/19 (1 October - 31 December 2018). 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>11</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

We asked the trust how many incidences of whistleblowing have you recorded in the last 12 months? The below shows the results:

<table>
<thead>
<tr>
<th>How many incidences of whistleblowing have you recorded in the last 12 months?</th>
<th>Total</th>
<th>Date Range, Start Date:</th>
<th>Date Range, End Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>41</td>
<td>01 April 2018</td>
<td>21 March 2019</td>
</tr>
</tbody>
</table>

Identification of any themes were highlighted in the quarterly report to Trust Board. The Trust had received significantly more cases which have elements of bullying or harassment than it had of issues relating to patient safety. The FTSU Guardian alerted the Trust to a number of reports of incidences relating to the women and children’s Directorate (now Family Health). As a result of this an investigation was commissioned which encouraged staff in the directorate to speak up as part of a specific review. A theme had been identified of staff speaking up as a result of concerns that some HR investigation processes were being protracted and delayed. Other themes included other workplace behavioural concerns where level of management response has been poor/slow leading to concerns being escalated, nature of how Trust communicates messages to staff regarding training compliance, Pilgrim ED and concerns from staff involved in HR matters about timeliness of process.

Between July 2018 and June 2019, the CQC received 15 whistle-blower concerns. Themes included, staff shortages, time available for staff to attend to patient’s basic needs, patients being moved during the night or numerous times, ED environment and wait times, poor management of EDs particularly, culture and concerns around the treatment of staff from BAME backgrounds.

The trust had a guardian of safe working (GOSW). The GOSW had been introduced to protect patients and doctors by making sure doctors were not working unsafe hours. The Guardian was required to produce a quarterly and an annual report to the Board to provide reassurance that trainees were working safely under the new contract and highlighting any safety issues, if necessary.
The trust had one GOSW who had been in post for three years. Prior to April 2019 there had been two GOSW in post with 2.25 PA (programmed activity) spread equally across the Boston, Grantham and Lincoln hospital sites. Following the decision to reduce to a single post it was agreed the PA would increase to 2.5. In addition, 0.6wte (whole time equivalent) support for the GOSW was agreed. However, the trust had been unable to successfully recruit to this role.

At our previous inspection in April 2018 we found there was not a statutory responsibility to report to the board on any issues with safe working hours. We were not therefore assured there was sufficient oversight or support of this role by the board. At this inspection we found the process for the GOSW report to the board was unclear with no formal feedback provided by the board to the GOSW. As a result, significant issues we identified at this inspection did not appear to have been considered by the executive team. For example, there was little support from the HR department and financial penalties to improve the training and working experience of all doctors were frequently late to be addressed, often by months.

A bi monthly junior doctor forum had been set up for doctors 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. However we found, issues and concerns identified through the junior doctor forum and raised by the GOSW had not been addressed or resolved at business unit level. For example, lack of rest facilities and appropriate meal breaks.

As of 12 July 2019, core learning compliance for mandatory training (trust wide) was 91.98%. This was below the trust target of 95%.

The trust had launched a new individual performance management process in April inspection 2018. The appraisal system aimed to support staff development, not all staff were having appraisals when they were due, however there had been an improvement. As of 12 July 2019, 72.74% of eligible staff were appraised. This was below the 95% target set by the trust. 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 still “paper exercise” and they rarely found them meaningful. This was the case at our last inspection

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. This was still the case at this inspection. 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. At our last inspection the trust was not fully compliant with the duty of candour. At this inspection we Trust wide data as of June 2019 showed that verbal compliance when duty of candour was required was 100% a significant improvement on the 46% in March 2018 and for written duty of candour 76%, which showed significant improvement on February 2018 compliance at 16%. Data from April 2018 to June 2019 had shown an upward trend in compliance.

**Sickness absence rates**

The trust's sickness absence levels from February 2018 to January 2019 were consistently higher than the England average. The rates at the trust followed a similar trend to that nationally with higher sickness absence in the winter months.
In the 2018 General Medical Council Survey the trust performed worse than expected for five indicators (teamwork, overall satisfaction, clinical supervision, supportive environment, and educational supervision) and the same as expected for the remaining 13 indicators.

<table>
<thead>
<tr>
<th>Survey area</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum coverage</td>
<td></td>
</tr>
<tr>
<td>Educational governance</td>
<td></td>
</tr>
<tr>
<td>Reporting systems</td>
<td></td>
</tr>
<tr>
<td>Rota design</td>
<td></td>
</tr>
<tr>
<td>Teamwork</td>
<td></td>
</tr>
<tr>
<td>Overall satisfaction</td>
<td></td>
</tr>
<tr>
<td>Clinical supervision</td>
<td></td>
</tr>
<tr>
<td>Clinical supervision out of hours</td>
<td></td>
</tr>
<tr>
<td>Handover</td>
<td></td>
</tr>
<tr>
<td>Induction</td>
<td></td>
</tr>
<tr>
<td>Adequate experience</td>
<td></td>
</tr>
<tr>
<td>Supportive environment</td>
<td></td>
</tr>
<tr>
<td>Work load</td>
<td></td>
</tr>
<tr>
<td>Educational supervision</td>
<td></td>
</tr>
<tr>
<td>Feedback</td>
<td></td>
</tr>
<tr>
<td>Local teaching</td>
<td></td>
</tr>
<tr>
<td>Regional teaching</td>
<td></td>
</tr>
<tr>
<td>Study leave</td>
<td></td>
</tr>
</tbody>
</table>

(Source: General Medical Council National Training Scheme Survey)
Governance

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Processes were not yet embedded across the organisation. Staff at all levels were not always clear about their roles and accountabilities. However, there were regular opportunities to meet, discuss and learn from the performance of the service.

Board Assurance Framework

The trust provided their Board Assurance Framework, as of February 2019, which detailed three strategic objectives and accompanying risks within each. A summary of these is below.

1. Patients: Providing consistently safe, responsive, high quality care
2. Services: Providing efficient and financially sustainable services
3. People: Providing services by staff who demonstrate the trust’s values and behaviours

Underpinning the strategic objectives were outcomes, linked to the corporate risk register, of which there were 15. When deciding on the assurance rating for each outcome the following key was used:

- Red: Effective controls may not be in place and/or appropriate assurances are not available to the board
- Amber: Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
- Green: Effective controls are definitely in place and board are satisfied that appropriate assurances are available

(Source: Trust Board Assurance Framework – February 2019)

The chief executive was responsible and accountable to the trust board for the delivery of the trust’s plans and objectives. They discharged the responsibility through executive directors and divisional clinical directors who collectively formed the Trust Management Group (TMG).

The TMG reported directly to the trust board. It consisted of the senior clinical leadership team and trust executives, under the leadership of the chief executive. In doing so it connected clinical services and the corporate and executive functions to the trust board. TMG met twice per month: Once to focus upon strategy, policy development and transformation and once to focus on delivery and risk.

The board had three sub-committees which were responsible for giving assurance on key elements of the BAF. Each committee was chaired by a non-executive director:

- Quality Governance Committee - Quality and safety.
- Workforce, Organisational Development and Transformation Committee - Staffing, organisational development and transformation.
- Finance, Performance and Estates Committee - Money, targets and estates.

Terms of reference for each committee had been reviewed to align to the new operational structure. In addition, there was also a fourth committee, the Audit Committee. The Audit Committee was chaired by a non-executive director and provided an independent and objective review on the adequacy of the trust’s control and governance systems, including audit arrangements (internal and external), financial systems, financial information, assurance arrangements including governance, risk management and compliance with legislation. All non-executive chairs of sub-committees attended the Audit Committee to consolidate assurance on systems of control.

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. Since our 2018
inspection significant changes had been made in relation to audit. The trust now had both internal and external auditors. Where previously, there was lack of clarity around audit schedules and sign off, a process had been put in place involving the chair of each of the sub-committees and the board. All actions and recommendations from the outcome of audits were tracked with the internal auditors having clear oversight of where the trust were with outstanding actions. For example, we were told there were a number of outstanding actions following the job planning audit.

Internal audit plans were developed at the start of the financial year and the audit programme was approved by non-executive directors at the Audit Committee. All internal audits were completed on time in 2018/19, and the chair of the audit committee expected all outstanding internal audit actions to be completed by October 2019. The 2019/20 internal audit plan included work on: estates procurement; the new operating model; financial systems and recording of efficiencies; and quality accounts. There was no internal audit plan related to the trust’s largest risk, workforce.

The trust had a BAF management process in place. The trust board assigned each strategic objective of the 2021 Strategy to a lead assurance committee. Outcomes under each strategic objective were aligned to a lead committee or reserved for review by the trust board.

The process for routine review and update of the BAF was:

- The corporate risk register was maintained by the lead executive, in accordance with the risk management policy.
- The BAF was updated with any changes to those corporate risks recorded within it; the trust board decided which corporate risks were significant enough to warrant inclusion on the BAF, based on recommendations from committees.
- The lead assurance committee (or trust board, where applicable) reviewed the management of risks to each required outcome (as part of their regular work programme), through evaluation of reports and risk assessments provided at committee by executive leads.
- The lead committee identified any gaps in controls or assurance and ensured there were appropriate plans in place to address them.
- The lead committee decided on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance.

To facilitate this process, each committee would receive regular reports from specialist groups, executive leads and other sources which provided management information and analysis of relevant key risks, to enable the committee to make a judgement as to the level of assurance that could be provided to the board. All reports to committees were firstly reviewed and approved by the executive lead.

Since our last inspection, we saw there had been a lot of progress to develop the BAF and make this a working and useful document. We saw the BAF effectively captured the risks to delivery of the strategic ambitions and performance for the trust board. Work had been done to strengthen the BAF through board development days and the BAF was reviewed at assurance committees and at board. Future work was planned to involve how the BAF could guide the assurance committees agendas. Executive and non-executive directors told us the Chair encouraged scrutiny on BAF at board to lead discussions.

The trust had a corporate governance manual in place which set out the running of the trust from a corporate perspective. We reviewed this manual and found it appropriate. However, it stated a review date of January 2019 and this had not happened. Within the document it referred to risk appropriately and talked about the risk strategy and policy. This was not made available to us during our inspection.

The trust had a governance reference guide for staff; ‘How we run and make decisions within ULHT’. This document clearly set out the trust’s strategy, vision and values. It showed the organisational structure that was in place in order to provide assurances around the quality of services provided. It identified structures within the trust for example, specialties, divisions and business units and their role with regard to governance. To support this document there was a quality governance toolkit. This was a ‘working’ document for staff as to how governance functioned at a practical level throughout the trust.
Incident reporting rates had increased year on year as trust processes had improved and awareness of what and how to report had grown. The emergency departments reported the most incidents and also had the highest proportion of significant harm incidents. Delayed diagnosis or treatment was the most common factor. The most frequent type of medication incident concerned omitted doses. Themes from serious incidents over the past 12 months included; failure to follow guidelines and delayed escalation for hyperkalaemia; management of deteriorating patients (including sepsis); unsuspected findings in Radiology and reliance on locum doctors. Pressure ulcers accounted for 43% of serious incidents and patient falls 12%.

Multi-disciplinary reviews took place during serious incidents investigations, to share learning and develop improvement plans with affected services. Final reports were shared with those involved in investigations, for dissemination within specialties. Patient Safety Briefings were used to highlight and communicate key messages from investigations to a wider clinical audience.

We saw an improved approach to action planning following investigations, focussing on policy and process issues so the trust could evidence change in practice and measure outcomes in terms of reduced incident frequency and severity. Trends in incident reporting, including analysis by category and location, were highlighted in regular reports to patient safety group and upwards to quality governance committee and trust board. A regular report was provided to trust board regarding progress of high profile cases and any learning identified through investigations and coroner's inquests. The trust had developed a policy for analysing and learning from patient safety incidents, complaints, claims and coroners inquests.

At our 2018 inspection, we found a lack of governance processes around the procedures to ensure locum staff were suitable to work in the organisation. At this inspection we found, an external medical recruitment agency guaranteed compliance with NHS Employment checks for all locum staff ensuring they were suitable to work in the organisation. This included but was not limited to qualifications, skills, experience, training, health, right to work, disclosure and barring service checks and such other criteria that the trust might require. We saw the trust had a robust process for checking ongoing compliance. In addition the trust’s compliance manager at the recruitment agency would review, on a rolling six month basis, each locums’ compliance generally.

The arrangements for governance and performance had been recently reviewed and there appeared to be a clear structure in place. This new governance structure had not yet had the opportunity to be fully tested but staff seemed enthusiastic about how it would work. The new Trust Operating Model had a structure for overseeing performance, quality and risk. However, staff at all levels of the organisation were not always clear on their accountabilities.

At this inspection we were not assured effective governance arrangements were in place to assure the board of the quality and delivery of surgical care to children. Previous requirement notices, issued at our 2018 inspection, in relation to children and young people had not been addressed sufficiently. We subsequently issued a section 29a warning notice.

Governance arrangements for safeguarding, at all levels of the organisation, were in place but not, always effective. The director of nursing was the executive lead for safeguarding; in addition to a named consultant; named nurse for safeguarding children; a named professional for safeguarding adults, and a Named midwife for safeguarding. These professionals provided training, advice and support to staff, patients and other agencies.

The trust worked in partnership with the local authority to safeguard vulnerable adults and children/young people. The local authority had its own safeguarding adult board (LSAB) and safeguarding children board (LSCB), and the trust was represented by the named professionals. The safeguarding boards maintained and developed multi-agency processes to assist in safeguarding adults and children/young People; and to co-ordinate what action was taken by each individual agency to ensure responsibilities were met.

In order to ensure the trust’s responsibilities were met, there was an established safeguarding committee, which reported to the trust board. At the time of our inspection, the committee was in the process of progressing the work plan for 2019-20, to ensure there was a clear focus for prioritising tasks over the coming year.
Policies, procedures, protocols and frameworks relating to safeguarding were in place to support staff in their decision making. However, during our inspection, we found a number of important policies and/or guidelines that were past their review date and six out of the nine policies and/or guidelines did not have a disclaimer identified, advising staff to ‘interpret the information with caution’. These included:

- Child sex abuse guideline – due for review August 2018.
- Missing patient policy – due for review March 2017
- Safe transfer of children/young people from ED - due for review August 2018.
- Safeguarding adults policy - due for review January 2019.
- Safeguarding supervision policy - due for review September 2018.
- Missing patient policy – due for review March 2017
- Safe transfer of children/young people from ED - due for review August 2018.
- Safeguarding adults policy - due for review January 2019.
- Safeguarding supervision policy - due for review September 2018.
- Children Act notification policy - due for review September 2018.
- PREVENT implementation policy - due for review November 2018.

We were not assured appropriate clinical oversight in prioritising policy reviews was in place. We discussed the policies and/or guidelines listed above with the director of nursing who was aware but told us the reviewing of policies and/or guidelines was led by clinical governance.

Papers for board meetings and other committees were of a good standard and contained appropriate information. We reviewed a number of papers as part of our inspection including for example, minutes from board meetings, the audit committee and the finance committee. Minutes were found to be clear and well presented with clear actions identified.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance. However, systems were not embedded across the organisation. Leaders and teams did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Performance management was a process by which the trust aimed to make sure individuals and teams throughout the organisation were aligned to meeting the agreed priorities.

The board monitored performance at a number of levels within the trust:

- At board level where the overall performance of the trust was reviewed.
- At the trust management group where the chief executive held executive directors and the senior divisional teams to account for delivering the trust’s priorities.
- At divisional and directorate management level.
- At individual level through appraisal mechanisms.

Structures existed to enable reporting from ward to board, and the comprehensive detail required for management of performance at the operational level. Reporting structures had been designed to accommodate differing needs of managers at all tiers of the organisation, and the information flow across these levels mirrored the trust’s management and governance structure. The aim of this approach was that operational performance measures were identified at as low a common denominator as possible.

Each month a performance review meeting (PRM) took place between executives and each division to check progress on the delivery of priority objectives, agree actions where progress still needed to be made and provide any support required. The divisional structure was still relatively new at the time of our inspection; therefore we were unable to establish the effectiveness of the PRM process.
Divisional performance reports were produced, monitoring operational performance, finance, quality and workforce. Following a similar format to the board report, these contained performance, workforce, finance and quality targets at divisional level. The purpose was to provide an insight into how the individual directorates contributed to the overall trust performance. Issues arising from performance meetings were escalated to the relevant board committee and to the trust management group where appropriate.

Assurance systems were not always effective and we were not confident risks and performance issues were escalated or managed appropriately. At our core service inspections, both in 2019 and previously in 2018, we identified areas of concern and poor performance. The trust oversight of these concerns had lacked the pace at which change was required and we did not see sufficient evidence on how performance in these areas was being monitored. Neither the BAF or corporate and divisional risk registers included a risk appetite statement. This makes clear the board of directors’ expectations in relation to the category of risks they expect management teams to identify and the level of such risk that is acceptable.

Pharmacy services were using The Model Hospital (NHS Improvement) to explore and compare quality in order to identify opportunities to improve. The Model Hospital is a digital information service designed to help NHS providers improve their productivity and efficiency. However, challenges within pharmacy services sometimes prevented the trust from providing a high quality service to all areas at all times. For example, due to the poor standard of the aseptic unit estate at Lincoln County Hospital this had resulted in the service being moved in its totality to the Pilgrim Hospital site.

As a result, pharmacy staff had worked flexibly to ensure that the trust continued to provide a safe and robust aseptic service which at times had resulted in utilising ward based staff to do this. This was undertaken in a planned way where safety and risk had been reviewed daily through monitoring/identifying the number of new admissions on each ward prior to utilising ward base staff to minimise risk. The aseptic service had been escalated to the quality and safety oversight group.

A business case had been submitted for an uplift to the aseptic workforce. As a result, the business case asked for 13 additional whole time equivalent (wte) staff. The trust was to fund the business case through a phase one / phase two programme of work which equated to six posts being funded as part of phase one and once fully recruited the trust was to look to further fund phase two. Since our inspection, phase one had now been fully recruited to with the plan for the identification of the funding for phase two being in progress and the adverts for the remaining seven posts were now live in the recruitment process.

The current aseptic service was on the risk register and the trust had, since our inspection, procured a mobile aseptic unit that had been installed and was going through the commissioning process. The risk was then to be altered once the unit was fully commissioned.

The Quality and Safety Improvement Plan (QSIP) set out a programme of improvement work to ensure the trust’s patients received safe care which promoted quality and safety. The 2018/2019 QSIP addressed issues of quality highlighted by the trust and by the CQC during our 2018 inspection. We were told by a number of directors that the board and assurance committees were sufficiently focused on the QSIP. However, they felt the QSIP was process driven and did not provide sufficient focus on the issues we identified in 2018. We saw, whilst there were key performance indicators (KPIs) in place, the QSIP was not always providing assurance that improvements were being made and sustained.

Paediatric surgery was part of the trust’s Getting It Right First Time (GIRFT) programme. The ambition of the programme was to identify examples of innovative, high quality and efficient service delivery by identifying areas of unwanted variation in clinical practice and/or divergence from the best evidence-based paediatric surgery care. To date a report and a set of recommendations aimed at improving the quality of care, optimising the volume of activity,
reducing expenditure, reducing complications, optimising procurement and stopping inappropriate treatments had been produced and the divisional team were working on plans to address these issues.

Ward accreditation was launched in October 2017, where wards across the trust were regularly scrutinised by a team of independent senior nurses and assessed against a range of patient care and safety measures and workforce requirements.

The trust identified 13 quality standards which the wards were measured against. During an inspection of a ward, the senior nursing team would look at many areas of care including how falls and pressure ulcers are prevented on the ward, how the correct nutrition for patients is maintained, the experience of patients, the workforce in the area, infection prevention performance and the end of life care provided.

Each ward was given a rating of red, amber or green based on how it scored against the 13 standards. The ward team would then be supported to develop and implement an improvement plan to further enhance the quality of care and patient experience before the next ward accreditation visit. At the time of our well led inspection 21 wards had been rated as green.

Ward accreditation was regularly discussed at board and we saw board papers that reflected where discussions had taken place.

The trust had £236 million back log of maintenance, of this £101 million was critical infrastructure statutory/mandatory maintenance. There was a risk management process in place to support prioritising key risks to service delivery and patient safety, however this was not always effective. For example we found that action to address a concern in relation to low level heating was escalated following an incident in relation to patient safety. This was a result of insufficient funds to address maintenance work. Risks were only allocated capital if they were rated as a “red red” risk. Leaders and teams told us the estates issues were “horrendous” and the physical infrastructure “poor”. The level of risk the trust was carrying around estates was of particular concern and there was a sense from talking to staff and leaders that the problem was too considerable to ever be fixed.

Across services, over 30 ‘high risks’ were for estates. Without exception, all executive and non-executive directors declared the infrastructure as one of their top risks. At the time of this inspection the estates strategy was being developed by the director of estates. Further work was being done to refresh this work, supported by external advisors and was to be reviewed by the board in September 2019. The trust had a significant capital maintenance backlog issue but lacked the funding to address this backlog.

Infection prevention and control was held in the director of nursing’s portfolio and as the director of IPC (DIPC) they led a team of four IPC links (one across each of the four hospital sites). Overall cleanliness audits were negatively influenced by the estates infrastructure and as such the DIPC team were represented at the estates priority group in order to provide an understanding of the importance of IPC.

**Finances Overview**

Financial performance was reported to the board and the finance, performance and estates committee which met monthly. Financial performance was reported in the integrated performance report, which was produced monthly. The finance team also reported on the delivery of financial efficiency plans to the financial transformation group which met monthly.

The trust had devolved budgets, with ownership of cost improvement and financial plans at divisional level. The trust had recently streamlined divisional management structures to strengthen lines of accountability.

There were regular performance meetings held with executive and divisional management to
monitor financial performance. The trust had a business partner model, with business accountants assigned to division management. However, the maturity of relationships between finance and divisions remained variable.

The trust had a business case process in place with a standard finance template for recording the cost benefit analysis. Interviews with stakeholders however identified the need to improve accuracy of cost estimations and tracking of benefits. The trust also had a capital and revenue investment group to ensure the prioritisation of investments was in line with the trust’s objectives.

As a result of a deteriorating financial position, the trust was placed in financial and quality special measures in 2017/18. The chief executive and director of finance met with NHS England and Improvement on a monthly basis to report on progress, highlight risks to delivering financial improvement and agree actions to mitigate financial risk. As part of the trajectory to bring the trust back to financial balance, the trust provided NHS Improvement (NHSI) with a financial recovery plan (FRP) that supported financial improvements over 18 months. For 2018/19, the forecast deficit submitted was £89.4m but the current forecast showed an improvement of £1.2m to give a revised forecast deficit of £88.2m.

For 2019/20, the FRP forecast a deficit of £75.2m, subsequently the trust had been offered a control total of £70.3m. To deliver the 2018/19 and 2019/20 FRP forecast, the trust had invested significantly in 'turnaround' support. This support included a turnaround director, external partner and other project management support.

The trust received formal notices around fire compliance and this had resulted in significant external capital funding being made available to support the improvements required. In 2018/19 the fire spend was forecast to be £17.0m with a further £15.4m to be spent in 2019/20. The Trust was working on a recruitment strategy to reduce its reliance on premium rate agency staffing. This would support the delivery of a financial efficiency programme and support improved operational performance.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£437.3m</td>
<td>£433.2m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£56.8m)</td>
<td>(£97.1m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£494.1m</td>
<td>£530.3m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£47.9m)</td>
<td>(£48.6m)</td>
</tr>
</tbody>
</table>

The budget deficit reported in 2017/18 was slightly higher than the previous year. At the time of reporting in March 2019, projections for 2018/19 indicated that the budget deficit would increase by over £25m before decreasing again in 2019/20.

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The challenge and risks to deliver the financial and quality improvement plans were understood and the leadership team was committed to addressing this. However, the trust did not appear to be working at pace to ensure mitigations were implemented to avoid a further deterioration in their financial and quality position this year.

The trust had a risk management policy that was approved in May 2019. The content of the policy reflected our conversations with senior executive directors. We saw there was a clear focus on managing risks within the organisation. Structures and processes were in place to manage risk however, processes were in their infancy and not yet fully embedded. We heard there was a dependence on the effective functioning of the triumvirates for risk management to
succeed and become embedded.

**Trust corporate risk register**

The risk register at the trust reflected the board assurance framework. The trust provided a document detailing their 11 highest profile risks, as of March 2019. Each of these had a current risk score of 16 or higher (out of 25).

<table>
<thead>
<tr>
<th>ID</th>
<th>Title</th>
<th>Description</th>
<th>Risk score (current)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4175</td>
<td>Management of emergency demand (corporate)</td>
<td>If the volume of emergency demand significantly exceeds the ability of the trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within the trust; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards.</td>
<td>20</td>
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<tr>
<td>4362</td>
<td>Workforce capacity &amp; capability (recruitment, retention &amp; skills)</td>
<td>If there is a significant reduction in workforce capacity or capability across the trust; Caused by issues with the recruitment and retention of sufficient numbers of staff with the required skills and experience; It could result in sustained disruption to the quality and continuity of multiple services across directorates and may lead to extended, unplanned closure of one or more services which has a major impact on the wider healthcare system.</td>
<td>20</td>
</tr>
<tr>
<td>4383</td>
<td>Substantial unplanned expenditure or financial penalties (corporate)</td>
<td>If the trust incurs substantial unplanned expenditure or financial penalties within the current financial year; Caused by issues with budget planning, budgetary controls, compliance with standards or unforeseen events; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.</td>
<td>20</td>
</tr>
<tr>
<td>4382</td>
<td>Delivery of the Financial Recovery Programme (corporate)</td>
<td>If the trust becomes unable to delivery key elements of the Financial Recovery Plan within the current financial year; Caused by issues with the design or implementation of planned cost reduction initiatives; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.</td>
<td>20</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>4405</td>
<td>Continuity of aseptic pharmacy services (corporate)</td>
<td>If there is a critical failure in the provision of aseptic pharmacy services within the trust; Caused by issues with the condition of the facilities or the staffing capacity and capability required to maintain the service to the required standards; It could result in significant disruption to multiple services which impacts on the care and treatment of a large number of patients. October 2018 - Contamination of isolators (increased microbiological contamination of critical plates in isolators). Probable cause - increased workload and capacity. Consequence - product’s contamination and patient safety.</td>
<td>20</td>
</tr>
<tr>
<td>3520</td>
<td>Compliance with fire safety regulations &amp; standards (corporate)</td>
<td>If the trust is found to be systemically non-compliant with fire safety regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.</td>
<td>16</td>
</tr>
<tr>
<td>3720</td>
<td>Critical failure of the electrical infrastructure (corporate)</td>
<td>If the trust experiences a critical failure of its electrical infrastructure; Caused by issues with the age and condition of essential equipment and the availability of resources required to maintain it; It could result in significant disruption to multiple services across directorates, impacting on productivity and the experience of a large number of patients.</td>
<td>16</td>
</tr>
<tr>
<td>4384</td>
<td>Substantial unplanned income reduction or missed opportunities (corporate)</td>
<td>If the trust experiences a substantial unplanned reduction in its income or missed opportunities to generate income within the current financial year; Caused by issues with financial planning, an unexpected reduction in demand or loss of market share; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial</td>
<td>16</td>
</tr>
<tr>
<td>4146</td>
<td>Effectiveness of safeguarding practice (corporate)</td>
<td>If there is a significant, widespread deterioration in the effectiveness of safeguarding practice across the trust; Caused by fundamental issues with the design or application of local policies and protocols; It could result in multiple incidents of significant, avoidable harm affecting vulnerable people in the care of one or more directorates.</td>
<td>16</td>
</tr>
<tr>
<td>3688</td>
<td>Quality of the hospital environment (corporate)</td>
<td>If the trust is unable to maintain a hospital environment and facilities that meet the expectations of patients, staff and visitors and the requirements of services across all of its sites; Caused by the condition of the estate and facilities and issues with maintenance and development; It could result in widespread dissatisfaction which leads to significant, long term damage to the reputation of the trust and may lead to commissioner or regulatory intervention.</td>
<td>16</td>
</tr>
</tbody>
</table>
If the trust experiences a critical failure of its mechanical infrastructure (including ventilation, steam, cold water, heating, medical gas pipeline systems and lifts); Caused by issues with the age and condition of the infrastructure and the availability of resources required to maintain it; It could result in significant disruption to multiple services across directorates, impacting on productivity and the experience of a large number of patients.

(Source: Trust Corporate Risk Register, March 2019)

Key risks for the trust related to workforce, finance and the estate. There was a workforce improvement plan with four key workstreams which was being managed by the HR team. Progress in delivering this plan was mixed with some areas of good progress and some areas of delay. The finance improvement plan was a one-year strategy set out in the financial efficiency programme (FEP) which was managed by an interim team (the senior finance lead and the PMO). Risks to delivering the FEP were identified and understood, but not mitigated at the time of review. Between April and June 2019, the FEP delivered headline numbers as planned, but delivery of these relied on non-recurrent actions.

Actions agreed to manage risks at board sub-committee meetings were not always closed in the timeframes captured on the action log. Non-executive board members accepted that further work was required to improve risk management at the trust as they noted that RAG rating presented to the board did not always capture the impact of action taken to address risks.

The governance team were working hard to develop systems to identify learning from incidents, complaints and safeguarding alerts and make improvements. However, this was not currently embedded across the whole organisation, nor was there consistent ownership at divisional level.

We saw that complaints data and patient experience data although presented at the quality and safety oversight group and quality governance committee it was done in silo and therefore themes were not always triangulated. The trust told us there were plans to pull a quarterly report to triangulate complaints, litigation, incidents and pals data (CLIP), however this had not happened at the time of our inspection. The patient experience lead told us it was likely to add an additional element to this report to track safeguarding concerns and would be known as the CLIPS report.

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

Data was not always reliable. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Improvements were required to information management. The trust remained reliant on significant manual systems which were inefficient. There was a project funded internally to support the further exploitation of trust systems in respect of provision of a single source of data that fed into dashboards to support data quality improvements, business decision making and supporting the performance management framework process.
The inefficient manual clinical processes were discussed with the inspection team and the trust’s plans around the digital strategy were described. A major part of the strategy was to digitalise health records and medicines management through the electronic health records and electronic prescribing projects. These were described to us as significant undertakings requiring capital resource as well as workflow and cultural changes. Funding was to be provided by a combination of both internal and external funding.

Financial reporting to board, committees, financial groups and system partners was consistent. Review of the financial board report identified that the financial position was presented with context such as activity performance to aid understanding and interpretation. However, the report did not include risks/mitigations to delivering the financial plan.

Stakeholders interviewed, indicated that improvements were required to make divisional finance reports more insightful and to provide a better understanding of the risks to the reported position. This had been recognised by the director of finance and investment was being made in a new finance system to support improvements in financial reporting.

The board reviewed performance reports that included data about the services. The integrated performance report was under review at the time of our last 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. At this inspection we found, the trust were incorporating the use of statistical process control (SPC) charts into their integrated performance report. SPC charts enabled the trust to track the impact of improvements and provided assurance of the reliability and accuracy of the data provided.

The trust’s integrated performance report was a monthly report which went to the trust board, providing an overview of performance against all business-critical performance indicators. The report highlighted key areas of success or concern and actions being taken to address the issues. Performance was visually displayed in the form of tables and charts, which showed historic performance and trends.

Information used in reporting, performance management and delivering quality care was developing to ensure it was valid and reliable. However, there was scope to improve systems and information to support business decisions and financial improvements in the organisation.

Divisional performance reports were produced, monitoring operational performance, finance, quality and workforce. Following a similar format to the board report, these contained performance, workforce, finance and quality targets at divisional level. The purpose was to provide an insight into how the individual directorates contributed to the overall trust performance.

A Data Quality Assurance Group met monthly to discuss key data quality issues within the trust. This was primarily focussed on some key internal systems within the trust. The group looked at data flows that affect billing, as well as those flows that affect externally reported KPIs, such as Ethnicity on the NHS Digital SUS+ Data Quality Dashboards. The data quality team had undertaken a series of roadshows with outpatient staff and ward clerks to emphasise the importance of data quality.

The trust engaged an external company to conduct internal audits and had completed a data quality audit that gave complete assurance. The key areas for focus were structure of the data quality team and operational team input into reviewing and fixing data quality items. This was being addressed through the data quality assurance group which met monthly. Significant assurance was given by an internal audit report on healthcare income which was reliant on data captured in medical notes.

There were various board sub-committees that challenged KPIs and data quality. Members of the executive team and non-executives also challenged data quality and data recording/capture through their regular patient safety walkabouts around wards and clinical areas. The information governance committee, chaired by the deputy chief executive, had as standing agenda item for data quality and part of that was a review of the data quality risk register. Regular work was undertaken by the data quality team to review key reports on items that affected downstream reporting.
The data security and protection toolkit (DSPT) version one was released on 1 April 2018 and replaced the former information governance toolkit. The trust submitted information to the DSPT. This is an online self-assessment tool that allows organisations to measure their performance against the national data guardians 10 data security standards. All organisations that have access to NHS patient data and systems but use the toolkit to provide assurance they are practising good data security and personal information is handled correctly. The trust had not fully met all of the standards and an internal audit scored limited assurance. We saw an action plan in place which reflected the recommendations of the audit.

The trust had a data protection officer which was a mandatory requirement under the new General Data Protection Regulation (GDPR) legislation.

The trust were working to create a ‘superb interactive dashboard’ for patient experience. This was to include information from a real time patient survey in addition to artificial intelligence. It was to also bring together friends and family test data, complaints, PALS data and NHS choices.

The Accessible Information Standard (AIS) aims to ensure those with impairments or communication needs receive information relating to their healthcare in appropriate formats, and that they have access to appropriate support while attending the hospital. Since the AIS was published, the trust had worked on a structured approach to the implementation of the standard and delivered key areas of compliance and improvement for patients and service users. For example, the delivery of an eye clinic liaison officer service, the implementation of improvements for people with sensory impairments and a review of information technology systems and processes. More recently, the trust piloted deaf awareness training in the emergency departments. The training evaluated well and a proposal was being drafted to secure further training sessions for frontline staff.

Incidents, including serious incidents, were reported as required to the NHS National Reporting and Learning System (NRMLS) or the NHS Strategic Executive Information System (StEis) in a timely way.

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. However, the information provided did not always provide assurance to us. For example, following a serious incident at the trust whereby a patient had suffered significant harm, we asked for assurance that appropriate actions had been taken to prevent a similar incident occurring. The trust told us actions had been taken. However, we saw, during a visit to the area where the incident had occurred, insufficient actions had been taken to remove the risk.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The trust had a structured approach to engaging with people who used their services, those close to them and their representatives. We saw the trust had included and communicated with patients, staff, the public, and local organisations.

The trust board engaged with the public through formal routes such as patient stories at the board meeting, and informally through ward visits during the day and night. Board members also engaged with specific patient groups such as paediatric service users at Pilgrim Hospital.

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.
The trust sought to actively engage with people who were living with a learning disability and patients with physical disabilities. In May 2018 United Lincolnshire Hospitals NHS Trust and NHS Lincolnshire East Clinical Commissioning Group innovated the Hearing Lincolnshire’s ‘hidden voices’ engagement events, as a way to provide people from smaller and often lesser heard community groups a meaningful way of sharing their experience of the local NHS.

The trust vision was to hold at least two hidden voices events per year. Some of the events were to have a specific focus around the experience of patients and services users from the local areas, and others would focus on the experience of staff working for the local NHS.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. Primary engagement was with local health care partners revolved around collaborative governance arrangements for the STP predominantly the Lincolnshire coordinating board of the Lincolnshire Health bodies and the System Executive Team across Lincolnshire, including the Lincolnshire County Council representation. In addition, the trust worked collaboratively with a number of collective forums for example, the A&E delivery Board, chaired by the trust’s chief executive. The trust was also an active participant in the system wide integrated community care programme.

The trust and its system partners in the Lincolnshire STP were developing a long-term plan for health services in Lincolnshire. The trust and the wider STP system were engaging the public in this process through ‘Healthy Conversations’.

The trust undertook the last pulse check in June 2018 and 1540 staff responded. Results showed a continued decrease in the number of staff who would recommend the organisation as a place to work and a slight increase on the numbers of staff who would recommend the trust as a place to receive treatment.

The four areas where the trust showed significant improvement were:

- I am confident that my organisation would address my unsafe clinical practice concern
- In the last three months I have not felt pressure from my immediate manager to come to work despite not feeling well enough
- I have had training, learning or development in the last 12 months
- Senior managers act on staff feedback

The five areas where we showed a significant decrease were:

- I am able to deliver the care I aspire to
- In the last 12 months I have never personally experienced harassment, bullying or abuse at work from manager
- In the last 12 months I have never personally experienced harassment, bullying or abuse at work from other colleagues
- My immediate manager takes positive action on health and wellbeing
- Training helped me do my job more effectively

The trust was transparent and open with all staff about their performance and what was expected of them. The trust staff charter set out what staff could expect of the trust as an employer. Staff were able to share their views through surveys, discussion boards, social media and other technologies. The trust was very active on social media platforms. In addition, staff were invited to join in with the trust’s ‘big conversations’ when there were big issues to be discussed.

Sitting alongside the staff charter was the trust’s ‘personal responsibility framework’, underpinning the charter’s values and giving examples of the behaviours the trust would wish to see and those the trust would not wish to see. Based around the five core values, both the charter and personal responsibility framework were created for staff, by staff.

Members of the senior leadership team told us staff were actively encouraged to challenge current practices, this was a clear message we received from the chief executive. Staff had opportunities to become a ‘Quality Improvement Practitioner’ and support and learn from the (NHS) Academy of Fabulous Stuff ‘FAB’ where they could see or share ideas that had improved patient experience, staff welfare or improved safety and compassionate care.
Learning, continuous improvement and innovation

Not all staff were committed to continually learning and improving services. Most staff had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation. Participation in research was minimal.

The trust was part of the Lincolnshire STP who had supported the trust in work done, supported by external consultants, to review the acute service model. The health system was developing a long-term plan to provide sustainable acute services across Lincolnshire. This was to be published later this year.

The trust had engaged with the Getting It Right First Time regional NHS team. It implemented a pilot to improve orthopaedic services at the Grantham site which had improved services and service sustainability. The trust was also engaged with regional NHS operational productivity teams who were supporting the trust to develop plans to release efficiency savings and improve services.

Board sub-committees had standard self-review agenda items to try to improve the effectiveness of the committees. The Audit Committee chair used a self-assessment tool to develop and improve effectiveness.

The trust had been reliant on external consultancies to develop efficiency programmes and recognised the need to build its internal capability to support the development and implementation of improvement initiatives, as well as tracking of benefits.

The trust was strengthening its efficiency delivery infrastructure through implementing a new divisional management structure and reinforcing ownership and accountability of plan delivery through more robust performance management. However, there were still several vacancies in management roles, which continued to impact timeliness of development and implementation of initiatives.

Learning from deaths

The trust had a process in place for reviewing inpatient deaths in line with the National Quality Board's 'Learning from Deaths' guidance. The trust had recently employed Medical Examiner's (ME) to screen deaths within seven days in line with the Learning from Deaths policy. As the ME was not yet able to offer a five day screening service, a percentage of cases were reviewed in the first instance by specialty. The screening escalated concerns clinically or from the bereaved families to the relevant forums for further review.

The trust had set a target of 100% completion of mortality reviews. For the reporting period April 2018 to March 2019, 60% had been reviewed either by specialty of the ME. Of these 100% of learning disability deaths had been reviewed.

ME reviews with a clinical concern were escalated to the relevant specialty for further review and discussion for learning at specialty governance. Where there had been a community issue, inappropriate admission or discharge concerns these reviews were escalated to the Lincolnshire Mortality Collaborative. This is a multi-agency group of all the Lincolnshire Acute and Community representatives. Concerns from families are discussed with the ME and any that required escalation were referred to PALS.

The Lincolnshire Collaborative had identified both learning within hospital and in the community, work streams had been undertaken to ensure that Lincolnshire patients received the best care. The trust also had a monthly Mortality Assurance Group meeting (MoRAG) where case note reviews were escalated, if they were scored above one, for a further review and learning was to be shared if appropriate.

The trust ensured all learning disability deaths were reported to the LeDeR programme and participated in the Lincolnshire LeDeR group.

Shared Learning from thematic reviews had resulted in re-launching of care bundles, in-depth reviews in any alerting diagnosis, audits within the community for end of life care, in-hospital recognition of end of life; use of the SPICT and ReSPECT toolkits. In addition, patient safety
briefings had been disseminated across the trust for shared learning. For example; Hyperkalaemia, NG and Ryles Tubes, NIV and importance of reviewing and acting upon test results.

As part of this well led inspection, we reviewed the mortality review process for four inpatient deaths. Our review included a maternal death and the death of a patient living with a learning disability. We found;

- The proforma used for documenting the mortality review was not always fully completed.
- Forms were not always completed correctly. For example, one review was of a learning disability death. On the proforma, where the review related to a learning disability death, it asked ‘is there evidence that mental health/learning disability needs are identified’ the reviewer had put ‘not applicable’.
- The grading structure for ‘standard of care’ was appropriate and scored from 0 to 3. However, in the proformas we reviewed there was nothing to indicate why a particular grading had been applied. For example, 0 – no sub-optimal care.

Significant work had been done at the trust to address mortality with positive results. Nationally the trust were in the top 22% for low HSMR which was below expected limits at 89.42 (Apr 18-Mar 19). This equated to 208.21 less deaths than expected (Apr 18-Mar 19). Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect.

There was an appetite for innovation amongst some leaders, however, due to constraints innovation was not always seen as a priority. We found; the trust had a quality improvement programme in place which staff had received training on. We noted there was a lot of enthusiasm for the programme. However, not all senior leaders appeared to be fully committed to this programme to enable benefits to be realised.

The trust were developing a continuous improvement strategy on the back of the quality improvement programme. The trust had identified the quality improvement programme was a strategic priority, and the strategy aimed to set out the intended journey to embrace and embed continuous quality improvement as part of delivering the 2021 strategy and beyond.

The trust hoped to achieve this by building both individual and organisational capacity and capability, through a systematic approach, developing different levels of quality improvement expertise for different individuals and teams and support the practical application to deliver local improvements together with the bigger transformational strategic improvements. The new TOM was a good starting block to supporting this process.

Patient experience rounds were completed regularly on all ward areas to gain feedback on services. In maternity and neonates this feedback was used to make positive changes to services and gave the team the opportunity to feedback on initiative. An example of feedback and actions taken to improve services, is the implementation partners visiting 24/7 in all areas of maternity.

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>95%</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 in the last 12 months?</td>
<td>March 2018 – February 2019</td>
<td>5,165</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)
During our inspection we reviewed a random sample of complaints, one of which was a patient in vulnerable circumstances. Overall, responses were clear and covered the points raised by complainants. All complaints we reviewed had been responded to in a timely manner and if not there was evidence of ongoing communication with the complainant.

**Number of complaints made to the trust**

From March 2018 to February 2019, the trust received a total of 727 complaints. The highest number of complaints were for outpatients, with 25.0% of total complaints, followed by urgent and emergency services (24.6%) and surgery (18.8%).

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>182</td>
<td>25.0%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>179</td>
<td>24.6%</td>
</tr>
<tr>
<td>Surgery</td>
<td>137</td>
<td>18.8%</td>
</tr>
<tr>
<td>Medical care</td>
<td>128</td>
<td>17.6%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>32</td>
<td>4.4%</td>
</tr>
<tr>
<td>Maternity</td>
<td>20</td>
<td>2.8%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>17</td>
<td>2.3%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>13</td>
<td>1.8%</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>1.8%</td>
</tr>
<tr>
<td>End of life care</td>
<td>3</td>
<td>0.4%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>3</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

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

**Compliments**

From March 2018 to February 2019, the trust received a total of 27,936 compliments. The highest number of compliments were for medical care, with 32.3% of total compliments, followed by outpatients (27.0%) and surgery (19.0%).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>9,032</td>
<td>32.3%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>7,532</td>
<td>27.0%</td>
</tr>
<tr>
<td>Surgery</td>
<td>5,301</td>
<td>19.0%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>1,831</td>
<td>6.6%</td>
</tr>
<tr>
<td>Maternity</td>
<td>1,382</td>
<td>4.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>1,048</td>
<td>3.8%</td>
</tr>
<tr>
<td>Services for Children and Young people</td>
<td>438</td>
<td>1.6%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>436</td>
<td>1.6%</td>
</tr>
<tr>
<td>Critical care</td>
<td>398</td>
<td>1.4%</td>
</tr>
<tr>
<td>Out of scope</td>
<td>309</td>
<td>1.1%</td>
</tr>
<tr>
<td>End of life care</td>
<td>225</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Alongside the manual count of compliments received by wards and services there were an
additional 746 comments recorded. These were comments from patients, families and staff directly to the services and staff they encountered. The overriding theme was wanting to give thanks to people and complimenting the overall service. Good communication also featured highly.

A count of compliments and also a compliment to complaints ratio was included in patient experience reports and displayed within wards and departments. A new patient experience dashboard (SUPERB) included compliments data at a more granular level.

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

Accreditations

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

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

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
</table>

The trust reported that they lost Joint Advisory Group on Endoscopy (JAG) Accreditation in 2018 due to waiting times for patients not being in line with JAG standards. The trust had a bespoke visit by JAG in April 2019.

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

The trust were working in partnership with Carers FIRST to support the hospital community as a gateway hub, which would help to identify new carers. Working alongside colleagues in the integrated Health and Care Neighbourhood Teams, Carers FIRST had co-located staff within the acute hospital settings in Lincolnshire.

The hospital settings provided a timely interlude for carers to consider the impact that caring may have on their own wellbeing. Through proactive partnership working arrangements, Carers FIRST staff had been given access to ward’s following ‘ward rounds’ and were able to provide ‘light touch, on site’ information, advice and support to carers and follow up support in local communities involving locality based staff if necessary. Health professionals worked alongside Carers FIRST in preparations for hospital discharge.

The ‘Carer Hub’ was to provide the following:

- The hub would be manned for meet, greet and signposting support by ULHT volunteers and Carer First Volunteers so there is always someone there and this would not only ensure support at all times but could also by its central nature encourage more people to join our volunteer service.
- While Carers First currently have desk space within Adult Social Care, the hub will offer a central and more accessible location when required.
- Information and advice will be available through leaflets, arranging phone calls or through supporting people to search online.
- Patients, relatives etc. would know exactly where to go for advice and guidance.
- A desk space for the ULHT Dementia Practitioner who currently has an office hidden away in the discharge lounge at the far end of the hospital. The dementia practitioner visits wards...
across the hospital to see and assess patients living with dementia and also runs activities and interventions with patients and provides advice and support to their families.

- A desk space for the Alzheimer’s Society Dementia Family Support Service coordinator who in a similar way to the ULHT practitioner visits many of the wards but also sees a lot of families either when they come to the hospital or in their own homes to provide any advice and support they may need.
- For both of these staff being central and easily accessible will be a huge benefit.
- Provide a ‘hot desk space’ for other partner / visiting / peripatetic organisations such as Carers First, Dementia UK, Age UK, Boston Mayflower, local charities or support groups.

The trust had been engaged with the Academy of FAB NHS since its launch in February 2015 and was the first accredited ‘FAB trust’. The trust had one of the first FAB Ambassadors appointed and currently had four. Their role was to:

- Promote the FAB Academy to staff
- Share projects from other NHS organisation to use in the trust
- Encourage staff to share their projects on the website so others see their work and they could use the idea
- Promote and organise Change Week
- Over the past four years FAB achievements included:
  - Active FAB ambassadors 'in post'
  - Won two national FAB Awards
  - Led three Change Day campaigns in 2016, 2017 and 2018
  - Given the #Ultimate ULHT hashtag
  - Site visits by FAB founders
  - Visit to and subsequent Academy share about Lincoln Heart Centre led to it featuring in a national radio programme
  - ULHT project / initiative ‘shares’ to the Academy website during 2018 Fab Change Week and many throughout the last 3 years.
  - Patient Experience Conferences showcasing FAB.
  - Development of FAB Experience Champions
  - Inclusion of FAB within quality improvement and 2021 programmes
  - Inclusion of FAB in trust wide patient safety and health and wellbeing conferences.

Lincolnshire Talent Academy, led by United Lincolnshire Hospitals NHS Trust (ULHT), brought together health and care organisations from across the county to help recruitment and skills development for the trust's current and future workforce.

Initially set up to encourage younger people into the trust, the academy evolved into a partnership of health and care organisations dedicated to the engagement, recruitment and development of talent.

The partnership delivered proactive services to help recruitment and skills development of current and future workforce, while ensuring the portability and integration of skills across the health and care system. The partnership worked with students, schools, colleges and universities in addition to other agencies such as the Department of Work and Pensions to provide services for individuals from the age of 14.

The academy’s remit included careers inspiration, guidance and work experience, through to the management of apprenticeship training and support for apprenticeship trailblazer standards across stakeholders.
Acute services

Lincoln County Hospital

Urgent and emergency care

Facts and data about this service

Urgent and emergency services are provided by the trust at three sites across Lincolnshire: Lincoln County Hospital, Pilgrim Hospital, and Grantham and District Hospital. Lincoln County Hospital is the largest service.

The emergency departments based at Lincoln County Hospital and Pilgrim Hospital provide consultant-led emergency care and treatment 24 hours a day, seven days a week to people across Lincoln and the North Lincolnshire area. Grantham and District Hospital closes overnight. From January 2018 to December 2018 there were 147,382 attendances at the trust’s urgent and emergency care services. This inspection concerns Lincoln County Hospital.

After our last inspection of the hospital published in July 2018 we asked the trust to make the following improvements at Lincoln County Hospital:

- The trust must ensure all patients who attend the emergency department are triaged within 15 minutes of their arrival.
- The trust must ensure all patients brought in by ambulance are handed over to the department within 30 minutes and patients should wait no more than 1 hour from time of arrival to time of treatment.
- The trust must ensure all patients who attend the department are admitted, transferred and discharged from the department within four hours.
- The trust must ensure all clinical and non-clinical staff receive the appropriate level of safeguarding children training: as directed in the Intercollegiate guidance: Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (March 2014).
- The trust must ensure all staff in the emergency department attend mandatory training in key skills in line with trust policy, to meet the trusts own targets.
- The trust must ensure staff in the emergency department are applying the principles of antimicrobial stewardship.
- The trust should ensure the backlog of incidents are investigated and lessons learnt cascaded as a matter of urgency.
- The trust should ensure there is a positive incident reporting culture where staff get appropriate and timely feedback.
- The trust should ensure consultant presence in the emergency department meets the Royal College of Emergency Medicine (RCEM) recommendation of 16 hours per day.
- The trust should ensure all resuscitation equipment in the emergency department is safe and ready and ready for use in an emergency.
- The trust should ensure plans to refurbish the quiet room to meet the Psychiatric Liaison Accreditation Network (PLAN) standards
- The trust should ensure the emergency department participate in more clinical audit to be able to evidence care is being provided in line with national recommendations and best practice.

We inspected the service between the 11th and 13th June 2019. The inspection comprised an emergency care consultant, a nurse and a CQC inspector. During the inspection we visited key
areas in the emergency department such as majors, minors, resuscitation, the rapid assessment and treatment area, and the waiting area.

We spoke with ten nurses and nine doctors of various grades, eight managers, and seven people from outside the organisation who worked with the service daily. We spoke with nine patients. We reviewed 25 records, checked eight pieces of equipment and attended a bed meeting.

Details of emergency departments and other urgent and emergency care services

Lincoln County Hospital
- Accident and emergency department
- Paediatric emergency service
- Ambulatory care bay

Pilgrim Hospital
- Accident and emergency department
- Ambulatory emergency care

Grantham and District Hospital
- Emergency assessment unit
- Assessment and ambulatory care
- Accident and emergency department

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Activity and patient throughput

From January 2018 to December 2018 there were 147,382 attendances at the trust’s urgent and emergency care services as indicated in the chart below.

Total number of urgent and emergency care attendances at United Lincolnshire Hospitals NHS Trust compared to all acute trusts in England, January 2018 to December 2018

(Source: Hospital Episode Statistics)
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in 2018/19 compared to 2017/18. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from January 2018 to December 2018

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

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

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 service provided mandatory training in many key skills. Most staff completed this but not everyone had the highest level of life support training.

Mandatory training completion rates

Nursing staff received and kept up-to-date with their mandatory training. After the 2018 service inspection, we stated that the trust must ensure all staff in the emergency department attended mandatory training in key skills in line with trust policy, to meet the trust’s own targets. In February 2019 most nursing staff had been trained in most mandatory training subjects.

Lincoln County Hospital urgent and emergency care department

A breakdown of compliance for mandatory training courses as of February 2019 for qualified nursing staff in the urgent and emergency care department at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>66</td>
<td>72</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>65</td>
<td>72</td>
<td>90.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>65</td>
<td>72</td>
<td>90.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>64</td>
<td>72</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>63</td>
<td>72</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>62</td>
<td>72</td>
<td>86.1%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>62</td>
<td>72</td>
<td>86.1%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>60</td>
<td>72</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>56</td>
<td>72</td>
<td>77.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>53</td>
<td>72</td>
<td>73.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>51</td>
<td>72</td>
<td>70.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>25</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>44</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital’s urgent and emergency care department, the target was met for two of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

Mandatory training did not include skills in dementia or mental health awareness training, according to the information we were given. Staff did not always receive training to make them aware of the potential needs of people with mental health conditions, learning disabilities, autism or dementia. One of the qualified nurses had been on a dementia course but most nurses had not received formal training.

Staff at Lincoln County Hospital had received some training on sepsis management, including
the use of screening tools and care bundles. Leaders recognised that more training was needed to reinforce understanding.

The trust set a target of 90% for completion of mandatory training, with the exceptions of: Fraud awareness and infection prevention level one, which had targets of 95%; Local fire procedures and fire safety, which had targets of 100%; Immediate life support (ILS)/advanced life support (ALS) and medicine management training which had no targets.

Not everyone had the highest level of life support training. Band six and seven nurses had received their training. The trust was still rolling this out to band five nurses when we inspected.

Medical staff did not always receive or keep up to date with their mandatory training. This was an issue in all the trust’s hospitals.

Compliance at Lincoln County Hospital in February 2019 is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and diversity</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>9</td>
<td>11</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>9</td>
<td>11</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>8</td>
<td>11</td>
<td>72.7%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>8</td>
<td>11</td>
<td>72.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>7</td>
<td>11</td>
<td>63.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>6</td>
<td>11</td>
<td>54.5%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>5</td>
<td>11</td>
<td>45.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>4</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital’s urgent and emergency care department, the target was met for four of the 11 applicable mandatory training modules for which medical staff were eligible.

**Safeguarding**

**Staff did not always have an understanding of how to protect patients from abuse. Not all medical staff had training on how to recognise and report abuse.**

Our 2018 report stated that the trust must ensure all clinical and non-clinical staff receive the appropriate level of safeguarding children training: as directed in the Intercollegiate guidance: Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (March 2014).

Not all medical staff received training for their role on how to recognise and report abuse. Medical training on safeguarding fell short of trust targets. In February 2019, 72.9% of medical staff received training at any level of safeguarding rather than the target level of 90%. Medical staffing was dependent on locums and it was difficult to complete training and development.

Nurses received training for their role on how to recognise and report abuse. Nursing training on safeguarding had improved and the service was meeting trust targets for adults and on track to meet targets for children. Lincoln County Hospital statistics showed that not all eligible staff were trained at level 3 for safeguarding children, but this was due to be completed. When we inspected, there had been an increase in nurse Level 3b compliance. Although the department
was only at 72% compliance for Level 3a, everybody had a training date planned. There were three dual trained paediatric/adult care nurses, but two of these nurses were part-time. The two deputy sisters and a band five nurse were in the process of being trained. The matron estimated that 80% of eligible staff were trained on Level 3 safeguarding.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We spoke with staff about what they had done in certain scenarios and they explained policies to us

**Lincoln County Hospital urgent and emergency care department**

A breakdown of compliance for safeguarding training courses as of February 2019 for qualified nursing staff in the urgent and emergency care department at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>65</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>65</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>65</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>65</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>49</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital’s urgent and emergency care department, the 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible. The completion rate for the fifth module was just below the target, at 89.1%.

A breakdown of compliance for safeguarding training courses as of February 2019 for medical staff in the urgent and emergency care department at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>8</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital’s urgent and emergency care department, the 90% target was not met for any of the five safeguarding training modules for which medical staff were eligible. However, the completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them, but processes around safeguarding were not always robust. We reviewed serious incidents where patients who were at clear risk of harm had not been properly safeguarded, one with fatal consequences. Although staff could recognise when vulnerable people needed safeguarding, an audit in February 2019 showed that there were gaps in knowledge of processes, for example, information about processes which was not filtering down, and a lack of referrals to children’s social care. The service used the nationally recognised SAFER screening tool to assess risk of physical abuse to children presenting with an injury but when we reviewed records, this was not always completed. There was also a lack of compliance with chemical sedation, the Mental Capacity Act and best interests, and risk assessments.
However, the trust recognised this. They had also drafted a Child and Infant Abduction Policy where they realised this needed to be done.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Vulnerable people were not automatically flagged to the service. Their systems did not link to those of mental health organisations. The service had arrangements to identify and manage people at risk of domestic abuse, but this did not cover weekends. Since January 2019 an independent domestic violence advisor had been based at the department’s reception area on weekdays only. This role was to help the department complete Domestic Abuse, Stalking and Harassment referrals, train staff and assist with multi-agency risk assessment conferences.

Safeguarding governance arrangements were developing. Safeguarding supervision was not formalised, and the trust's safeguarding supervision and conscious sedation policies were due for renewal. Under the new trust operating model, divisions had new plans to manage safeguarding risks. The service’s matron was the designated adult safeguarding lead. There was a children’s safeguarding lead and leaders hoped this role would raise the profile of children’s safeguarding within the service. The service had a safeguarding meeting monthly with the trust safeguarding leads for adults and children.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Most areas of the emergency department were clean and had suitable furnishings which were clean and maintained. The service controlled infection risk in clinical areas. They kept equipment and the premises visibly clean. Cleaning records were up to date and demonstrated that all areas were cleaned regularly, although ward accreditation results suggested that sometimes this did not happen.

However, waiting areas were less clean. Patients complained to us that the toilets next to the main waiting area did not smell clean and this was made worse because the door was frequently left open.

Cleaning records were up to date and demonstrated that most areas were cleaned regularly. We checked in clinical areas.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff cleaning equipment before and after patient contact and labelling equipment to show when it was cleaned.

Staff followed infection control principles including the use of personal protective equipment. Hand hygiene audits for the emergency department at Lincoln showed between 98% and 100% compliance for the 12 months between June 2018 and May 2019. We observed staff washing their hands before during and after patient contact and using personal protective equipment when appropriate. (PPE).

A piece of work was undertaken by the trust between January and March 2019 (quarter four) which changed the way in which hand hygiene was assessed. Prior to this the trust would receive consistent 100% hand hygiene compliance in most areas and recognised that this probably did not reflect actual practice. The trust therefore changed the hand hygiene assessment methodology to better reflect a more accurate position and to show the areas where non-compliance needed support. During quarter four, the infection prevention and control (IPC) team briefed the trust IPC committee to advise that they expected hand hygiene numbers to decline as the new assessment tool was rolled out. This guided the IPC team on where they needed to focus their efforts to support improvements.

Environment and equipment
The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were not always trained in the safe use of equipment. Staff managed clinical waste well.

The layout of facilities did not promote timely or safe care. The area used for emergency care was cramped with limited facilities for resuscitation. Facilities for x-ray and CT scanning were next to the emergency department but theatres were some distance away. The hospital did not have a helipad.

The design of the environment did not follow national guidelines. Some of the facilities did not meet Royal College of Paediatrics and Child Health (RCPCH) standards for children, although the trust told us they did not see enough children to have to comply with these standards. We did not see an analysis of this. The department generally saw more than 70 children a week but demand was increasing. Children were not provided with waiting and treatment areas that were separate from adult waiting areas. Children remained in the main waiting area of the department for between 45 and 60 minutes. This meant that they sometimes shared the areas with patients who were aggressive and violent.

Children arriving by ambulance were placed in the rapid assessment and triage/treatment area corridor amongst adult patients whilst they were waiting to be assessed. During our inspection we observed a toddler with a high temperature, tachycardia (fast heart rate) and head injury moved to the rapid assessment and treatment (RAT) area because there was no space in majors and the paediatrics cubicle was occupied.

We also overheard discussions taking place during our inspection with regards to co-locating two children in the paediatric cubicle due to crowding in the majors area of the department. This posed a significant risk of avoidable harm to patients and not being able to provide patients with safe care and treatment.

Patients could reach call bells, but staff did not always respond quickly when called. This depended on workload.

Staff carried out daily safety checks of specialist equipment, but these were not always thorough. Not all equipment was in date. Our last inspection report said that the trust should ensure all resuscitation equipment in the emergency department was safe and ready for use in an emergency. Although there was a checklist which indicated that equipment on the resuscitation trolley in majors was checked every day, we found a tracheal tube which was past its expiry date of April 2019. We also found a three way tap on the Rapid Assessment and Treatment arrest trolley which was also beyond its expiry date of April 2019.

Staff did not routinely check equipment to ensure it was working correctly. During our inspection a paediatric diabetic patient started fixed rate insulin through an insulin pump at 4pm. The pump sounded an alarm every 10 minutes. It was not checked until shift change at 8pm and the insulin syringe still had 50 millilitres in it. The pump had not worked for four hours but no action had been taken. We were told the patient had not been harmed by this.

The fridge in majors appeared to be warmer than the required temperature range. We were told it was recorded at source by the clinical engineering department.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not complete risk assessments for all patients swiftly. They did not always remove or minimise risks. Staff did not always identify or act upon patients at risk of deterioration.

Staff did not always complete risk assessments for each patient on admission / arrival in a timely way.
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 in 10 months over the 12-month period from March 2018 to February 2019. Performance has been improving since November 2018 and in the most recent month reported, February 2019, the median time to initial assessment was eight minutes compared to the England average of nine minutes.

Ambulance – Time to initial assessment from March 2018 to February 2019 at United Lincolnshire Hospitals NHS Trust

![Graph showing median time from arrival to initial assessment]

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

Lincoln County Hospital – Ambulance Turnaround

Most patients brought in by ambulance were handed over within the target time of 30 minutes. Our 2018 inspection report stated that the trust must ensure all patients brought in by ambulance were handed over to the department within 30 minutes and patients should wait no more than 1 hour from time of arrival to time of treatment. Ambulance handover data for May 2019 at Lincoln showed that 35.4% were within 15 minutes, 70.2% within 30 minutes and 88.5% within 60 minutes.

Ambulance turnaround times were a continuing problem, especially after 5 pm, when demand increased significantly. Ambulance staff told us that the Rapid Assessment and Treatment (RAT) area helped them during the day, because it was easier to hand over to a nurse. A standard operating procedure was not yet in place for the RAT. Turnaround delays were likely on Monday nights when ambulances could potentially wait for up to two hours due to bed shortages. These problems were exacerbated by a lack of clarity about prioritising patients and lack of continuity in role due to the high number of locum doctors.

It was too early to say whether average ambulance turnaround times at Lincoln County Hospital would be sustainable through the winter. In February 2019, the average ambulance turnaround time was 54 minutes, in March 49 minutes, April 54 minutes and May 50 minutes. These average figures showed that ambulance turnaround took longer than at Boston Pilgrim Hospital or Grantham.

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.

These had improved from February to May 2019. According to the trust’s figures, the number of occasions an ambulance had to wait more than an hour for a clinical handover had reduced by 29% from 479 in February 2019 to 313 in May 2019. It was too early to say whether this would be sustainable during winter pressures.
Staff used nationally recognised tools to identify deteriorating patients but did not always escalate them appropriately. During our inspection of Lincoln County Hospital, five patients out of 13 we tracked had a National Early Warning Score ('NEWS') of five or more, indicating they would need to have a sepsis screen completed, in line with the Trust sepsis policy. When we inspected this was not done in two out of five cases on one day and one out of four cases on the next day.

Screening was not always timely. Although the trust had a Deteriorating Patient Improvement plan for quick and efficient sepsis screens to be in place by December 2018, this was not fully embedded. We found that sepsis screens could take place anywhere between 89 and 265 minutes after the initial NEWS trigger. The service also had difficulty sustaining screening within 60 minutes for children, achieving 100% in its audit in April 2019 but declining to 25% in May 2019. This posed significant risk of avoidable harm to patients as they were not being triaged/managed within the hour as per trust sepsis policy.

Some patients were not given antibiotics quickly enough. Our last inspection report in 2018 stated that the trust must ensure staff in the emergency department were applying the principles of antimicrobial stewardship. Two of the four patients who triggered positive for sepsis on the second day of our inspection did not receive antibiotics within the recommended 60 minutes. One patient received antibiotics at 112 minutes after their initial trigger and another patient received antibiotics at 129 minutes after their initial trigger. On the third day of our inspection data showed that a patient who had sepsis received antibiotics 100 minutes after triggering this, which did not meet the 60 minute standard. This posed significant risk of avoidable harm to patients as this was not in line with national guidance or trust policy. Evidence based practice states patients should receive antibiotics within an hour of the sepsis trigger being identified.

Staff did not always know about or deal with specific risk issues. Leaders explained to us that there was still a training need because some staff were not completing the sepsis screen correctly.

Staff did not complete appropriate risk assessments for each patient on admission / arrival or update them when necessary using recognised tools. During the inspection days we observed that children did not always get a clinical assessment undertaken within 15 minutes to determine priority category, supplemented by a pain score and a full record of vital signs. The trust had implemented a process whereby all adult patients following initial triage received a set of base line observations, however these were mostly performed by health care assistants. Health care assistants told us, and we observed that that this process was not the same for children because health care assistants were not trained to obtain observations for children. This resulted in a delay from the initial triage to the clinical assessment. We tracked the care of three children during our inspection who had presented with head injuries. They had been triaged to the minors area of the department without a full assessment of their needs. We found there was a doctor and nurse in the majors’ area of the department who could have treated these children in a timely way, however they were not made aware of these children until we intervened. The lack of an effective system for initially clinically assessing children posed significant risk of avoidable harm to patients.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health) (AMSAT).

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. (AMSAT)

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe.
The mental health triage form was not always used. We observed five patients with mental health difficulties arriving in the emergency department and saw a mental health assessment for one patient who requested the crisis team. The SAFER tool on the patient record was not always completed. Mental health triage forms were kept with the emergency department record; however this was not completed for six out of ten forms we looked at.

Risks to patients in the waiting area were not managed. The service recognised that patients who waited a long time were at increased risk. Protocols to best manage how best to monitor patients in the waiting area were not yet in place. Ideas included implementing re-triage arrangements for category three patients and locating a nurse in the waiting room in situations of high demand. Some patients left without being seen. The service relied on patients to tell them they were leaving. If staff were aware that a vulnerable person had left they rang the police or in the case of a minor, their parents or the school nurse/health visitor. They did not monitor this which left vulnerable patients at risk if they left the department.

Our 2018 inspection reported stated that the trust must ensure all patients who attended the emergency department were triaged within 15 minutes of their arrival. According to trust data, patients at Lincoln were triaged promptly. In week of our inspection daily triage figures showed that between 71% and 94% of patients were triaged within 15 minutes. The emergency department programme dashboard recorded that 92.3% of patients were triaged within 15 minutes in May 2019. The trust target was 75%. However, we observed the triage time logged by staff was the start of the initial observation, and not the triage decision.

Paediatric risk assessment was not fully embedded when we inspected. The service introduced paediatric observation priority scoring (POPs) in June 2019, however the delay in ICT support for this had led to problems. Staff needed reminding that this was to be used in conjunction with taking blood pressure and BM. Whilst levels of nurse paediatric skills was improving, this had not yet led to better assessment or triage.

There was no audit trail which showed that consultants signed off patients at risk. Before discharging patients from the service, consultants should see children under one, patients over 30 with chest pain, patients over 75 with abdominal pain and any patient who had returned after 72 hours to the department with the same condition. This was not necessarily recorded, and staff told us it did not always happen.

The service was improving communication around management of patient risk, but this was not fully effective. They had safety huddles to review patient risk across the department and ensure that nursing and medical staff were fully informed about the care of individual patients. This process was followed during handover times at the beginning and end of each shift but did not routinely happen every two hours as intended. We observed a handover huddle which reviewed flow, staffing paediatric patients, and other issues, such as any patients with mental health problems. There was a safety checklist for patients who were in department for a long time, and this was at the back of the patient record.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient’s mental health. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had a mental health lead who advised and assisted staff with mental health issues.

**Nurse staffing**

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm.
and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Nurse staffing rates had reduced between the year ending March 2018 and February 2019. In March 2018 the ratio of actual staff to planned in A&E was 85%, whereas this was 82% in February 2019.

Lincoln County Hospital

Lincoln County Hospital reported the following WTE nursing staff numbers for the periods below for urgent and emergency care.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Accident and emergency</td>
<td>46.3</td>
<td>54.5</td>
</tr>
<tr>
<td>Ambulatory unit</td>
<td>12.5</td>
<td>13.7</td>
</tr>
<tr>
<td>A&amp;E attenders</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Integrated medicine management</td>
<td>7.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Alex Bay</td>
<td>0.6</td>
<td>11.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>67.5</strong></td>
<td><strong>87.2</strong></td>
</tr>
</tbody>
</table>

The emergency department had a high use of bank and agency nurses. In the first quarter of 2019/20, 7119 hours were filled by bank staff and 6188 hours by agency staff and 1467 hours were unfilled. Information given to us by the trust showed there had been an increase of 30% in bank and agency shift hours requested over the past year. However, leaders requested staff who were familiar with the service. Actual staffing did not always meet what was planned, and this was logged as a major risk on the department’s risk register. Bank and agency staff received a full induction.

Bank and agency use of qualified nursing staff at Lincoln County Hospital

The tables below show the numbers and percentages of nursing hours in urgent and emergency care at Lincoln County Hospital from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 160,450 total working hours available, 7.3% were filled by bank staff and 10.9% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 5.1% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E flow co-ordinators</td>
<td>4,111</td>
</tr>
<tr>
<td>Emergency care practitioners</td>
<td>26,359</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>129,980</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>160,450</strong></td>
</tr>
</tbody>
</table>

Non-qualified nursing staff
Of the 54,890 total working hours available, 27.6% were filled by bank staff and 0.2% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period, the trust was not able to fill 8.9% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2018 to February 2019</th>
<th></th>
<th></th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
<td>Bank usage</td>
<td>Agency usage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Emergency care practitioners</td>
<td>4,302</td>
<td>463</td>
<td>10.8%</td>
<td>0</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>50,588</td>
<td>14,676</td>
<td>29.0%</td>
<td>88</td>
</tr>
<tr>
<td>Total</td>
<td>54,890</td>
<td>15,139</td>
<td>27.6%</td>
<td>88</td>
</tr>
</tbody>
</table>

The service had high levels of vacancies, turnover and sickness. From April 2018 to March 2019, the trust reported a vacancy rate of 22.2% for Lincoln County Hospital urgent and emergency care department and 75% for A&E attenders (staff). During the same period, the turnover rate for A&E attenders was 50% and for Accident and Emergency staff, 8.1%. The annual sickness rate was 28.6% for A&E attenders and 3.8% for Accident and Emergency. The trust target was 4.5%.

The service did not always have enough nursing staff of all grades to keep people safe. Minors area staffing arrangements were minimal. A doctor worked there three days a week from 3 pm to midnight, then the rest of the time three advanced nurse practitioners treated patients. They did not have health care assistant support for plastering broken limbs.

The service aimed for a ratio of four patients to one nurse, but sometimes this could be exceeded. For example, if a nurse was allocated to Bay one and two and the Fit to Sit area, this would not meet the ratio because the Fit to Sit area alone could take a maximum of four people. In resus the ratio was two patients to one nurse and this was maintained.

The service did not have two registered children’s nurses on every shift. It aimed to have one paediatric nurse on every shift. It had three band 5 – 6 nurses who were dual trained to treat adults and children, but two of these nurses were part time. The clinical educator was also dual trained. There were 11 band four nurses who were trained to care for children. The service responded to our inspection by recruiting another qualified paediatric nurse for the evening shift.

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 follow up on 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.

The service had started to recruit new nursing staff to key roles. Recent information showed that out of 88.18 full time equivalent (fte) funded nurse posts across all grades, there were 25 full time equivalent (fte) posts vacant in June 2019, equivalent to 35% of the nursing workforce. Leaders had acted to reduce the vacancies and new staff, mostly experienced nurses (bank 6) joined the department in July 2019, reducing the vacancies to 20.6 ftes (23%).

The service reviewed its nurse staffing and skills mix. For example in November 2018 to reflect the changing needs of the department. It replaced three band five nurses with band four nurses. Two nursing associates were redeployed from Pilgrim Hospital The service aimed to ensure that there were always two experienced nurses (band sixes) in the department. There was a band 7 flow coordinator and a band 7 nurse in the department during the day. When we inspected, the matron was interviewing for 6 whole time equivalent band six nurse positions and 17 band fives posts.
Nurse staffing levels were adequate during our inspection. For example, overnight on the 12th June there were 10 registered nurses and eight of these were permanent trust staff. Two staff were regular agency staff. A band six nurse had been added to the rota to improve safety.

**Medical staffing**

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. The medical staff did not match the planned number on all shifts in each department.

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for urgent and emergency care.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>13.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>17.4</td>
<td>33.2</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>18.0</td>
<td>30.0</td>
</tr>
<tr>
<td>Total</td>
<td>48.4</td>
<td>78.2</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital the ratio of actual to planned medical staff deteriorated from 54.4% in March 2018 to 48.5% in February 2019. There was a similar reduction at Pilgrim Hospital although staffing at Grantham and District Hospital remained stable at 86.7% of plan.

The emergency department had a high rate of bank and locum medical staff usage. The service depended on a disproportionate number of locums. Recent information supplied by the trust showed that out of 43 medical posts (all grades) 19 (44%) of them in Lincoln emergency department were unfilled, including posts for two associate specialists, nine specialty doctors and three specialist trainees.

Managers made sure locums had a full induction to the service before they started work.

The service had high vacancy rates for medical staff. At Lincoln County Hospital urgent and emergency care department this was reported as 51.3% from April 2018 to March 2019, higher than the urgency and emergency care trust wide medical vacancy rate which was 46.4%.

The trust was starting to recruit doctors for all its hospitals. Working in partnership with the Emergency Care Intensive Support Team (ECIST), the trust started to increase the recruitment rate of junior/middle grade medical staff in urgent and emergency care. Four NHS locums currently working towards Certificate of Eligibility for Specialist Registration (CESR) qualification and 3 more in the pipeline due to start within the next three months who will also be working towards CESR qualification. A further ten middle grades are in the pipeline all to undertake CESR with a view to being substantively employed.

Support from Health Education England for the preceptorship and on-boarding of the new recruits was also in place. The trust planned to have full junior and middle grade medical staffing by the end of September 2019.

The service had high turnover rates for medical staff. From April 2018 to March 2019, the
The turnover rate in Lincoln County Hospital urgent and emergency care department was 37.1%, higher than 31.9% for medical staff in urgent and emergency care trust wide. This was higher than the trust target of 8%. Turnover data for medical staff includes trainee grades who tend to move between placements.

Sickness rates for medical staff was slightly higher than the trust target of 4.5%. From April 2018 to March 2019, Lincoln County Hospital reported a sickness rate of 5.5% for medical staff in urgent and emergency care.

The service did not always have a consultant on call during evenings and weekends. It had had improved consultant cover but needed to recruit to cover 16 hours in line with RCEM guidelines. Our last inspection report in 2018 asked the trust to ensure consultant presence in the emergency department met the Royal College of Emergency Medicine (RCEM) recommendation of 16 hours per day. The trust created the Emergency Physician in charge (EPIC) role to comply with this. The trust protocol for this stated that a consultant should cover morning afternoon and evening shifts on weekdays at Lincoln but a lower grade doctor, the emergency department senior decision maker (ST4) should cover the night shift between 22:00 and 08:30.

Weekend EPIC cover was over three shifts 08:00 to 12:30, 12:00 to 20:00 by consultants and 22:00 to 08:30 by an ST4 senior decision maker. This meant there was a gap between 20:00 and 22:00, and leaders were hoping to resolve this when they recruited. Weekday consultant cover was from 8 am to 18:00 pm in the Rapid Assessment and Treatment area (14 hours).

The senior paediatric doctor on each shift was identifiable by a plastic animal on their clothing. This doctor was trained in advanced paediatric life support and had oversight of the care and treatment of children.

The service had a skill mix of medical staff on each shift and reviewed this regularly. At the service at Lincoln there was a shortage of registrars which meant that sometimes consultants took on their roles; 14% of doctors were at the registrar level, compared to 34% nationally.

**Staffing skill mix**

In January 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 50 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>28%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>28%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>14%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>30%</td>
<td>21%</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
Records

Staff did not always keep detailed records of patients’ care and treatment. Records were mostly clear and up to date. They were not always stored securely. They were easily available to all staff providing care.

Patient notes were not always comprehensive. Sometimes they were incomplete. Records did not prompt staff to complete mental health assessments; six out of ten records we reviewed did not have these. However, we checked and allergies and clinical indications, dose and duration of antibiotics were clearly documented.

Staff could access records easily. Sometimes they were not kept securely when the patients were in the department. Despite this, they were placed out of public view and away from anyone from outside the service.

Patient records were paper based and 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.

Medicines

The service did not always use systems and processes to safely prescribe or administer medicines. Medicines were stored correctly.

Drugs were not always administered safely. During our inspection for example, an epileptic patient was incorrectly given maintenance doses of an anti-epileptic drug and had repeated seizures as a result. This was reported as an incident and investigated by the trust.

We were told that medicines for children were usually checked. Two paediatric nurses did this; if necessary a paediatric nurse from the children’s ward helped. There was a booklet to help with paediatric medicine dosages.

Staff stored and managed all medicines and prescribing documents in line with trust policy. We observed that drugs and controlled drugs were correctly stored in the department and locked away when required. Prescription pads were also stored and monitored correctly.

Patient Group Directions (PGDs) were in place so that nurses could administer medicines without a doctor being present. These were for medications such as nitrous oxide/oxygen, paracetamol, paracetamol for children, ibuprofen, and tetracaine gel. These PGDs were reviewed regularly.

New nurses spent half a day and had to complete supervised shift with the clinical educators to learn about patient group directions. The service did not have a lead for PGDs and was planning to fill the role within a few weeks.

Incidents

The service had improved its management of patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Our 2018 inspection report stated that the trust should ensure the backlog of incidents was investigated and lessons learnt cascaded as a matter of urgency; and that there should be positive incident reporting culture where staff get appropriate and timely feedback.
All staff knew what incidents to report and how to report them. Managers reviewed an incident as soon as it was reported on the electronic incident reporting system, especially if it was a moderate harm or serious incident.

Most staff received feedback from investigation of incidents, both internal and external to the service.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

There was some evidence that changes were made as a result of feedback. We were given the example of staff learning from a patient with respiratory failure. Blood gases were interpreted incorrectly and the situation was not escalated in time. Information was missing from the handover. The service planned to do mini-teaches and had circulated information to staff to minimise the risk of it happening again. Clinicians reviewed all patient deaths within the service at monthly mortality and morbidity meetings, analysed the quality of care and documentation and took action on any learning points.

Managers ensured that actions from patient safety alerts were implemented and monitored. We saw minutes from Acute Medicine Governance meetings which showed that attendees took action.

However, not all incidents were graded correctly. We saw incidents graded as no harm or low harm when they were likely to have a severe impact on a patient’s life.

The service was not up to date with its learning from incidents or mortality. Leaders told us had a backlog of incidents to review. They had asked a trust risk colleague to help with batching the incident reports up so that the service could process them and the learning from them. Staff did not consistently receive feedback when they had reported an incident and the trust was improving processes to reinforce this.

**Never Events**

The service reported one never event between March 2018 and February 2019. Managers shared learning about never events with their staff and across the trust.

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

From March 2018 to February 2019, the trust reported one never event for urgent and emergency care. This serious incident, which occurred in May 2018, related to the mis-selection of high strength midazolam during conscious sedation. It was classified as a medication incident meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 39 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from March 2018 to February 2019.

Breakdowns of the serious incidents by type and trust site are shown in the tables below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
</table>
### Diagnostic Incident Including Delay (Including Failure to Act on Test Results)

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>No. of Serious Incidents</th>
<th>% of Serious Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay</td>
<td>13</td>
<td>33.3%</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>7</td>
<td>17.9%</td>
</tr>
<tr>
<td>Medication incident</td>
<td>2</td>
<td>5.1%</td>
</tr>
<tr>
<td>Slips/trips/falls</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>39</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Treatment Delay

<table>
<thead>
<tr>
<th>Site Name</th>
<th>No. of Serious Incidents</th>
<th>% of Serious Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital</td>
<td>22</td>
<td>56.4%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>16</td>
<td>41.0%</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>39</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Safety Thermometer

The service was starting to use monitoring results well to improve safety. Staff collected safety information, but this was not shared with patients and visitors.

The trust had a ward accreditation scheme with a range of safety indicators. This included standards for infection control, patient deterioration, tissue viability and falls. In April 2019 the service was assessed as red for paediatrics, identifying the deteriorating patient, infection prevention, falls prevention and nutritional support. Ward accreditation dashboard results were not displayed for the public.

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 from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, four falls with harm and one new urinary tract infection in a patient with a catheter from March 2018 to March 2019 within urgent and emergency care.

### Prevalence Rate (Number of Patients per 100 Surveyed) of Falls and Catheter Urinary Tract Infections at United Lincolnshire Hospitals NHS Trust
The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

After our last inspection we said that the trust should ensure the emergency department participated in more clinical audits to be able to evidence care was being provided in line with national recommendations and best practice.

The service was still developing clinical audit arrangements when we inspected this time. The service conducted sepsis and triage audits, but staff did not always follow sepsis screening guidance. Information about recent serious incidents showed that good practice procedures were not embedded for chest pain or for evidence-based stroke care, for example, by notifying the stroke team promptly or thrombolysing the patient.

However, the service used some National Institute for Clinical Excellence (NICE) guidelines to ensure that care was evidence based and was building a more robust process to do this. Lincoln A&E Governance meeting minutes showed that the service used NICE implementation support tools such as those for baseline assessment, for example NG38 for assessment and management of fracture and CG69 for respiratory tract infections. We observed treatment where the Diabetic Ketoacidosis protocol was followed closely.

Staff protected the rights of patients subject to the Mental Health Act 1983. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.(AMSAT).

Nutrition and hydration
Staff did not always give patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff were not always able to ensure that patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Healthcare assistants ordered a selection of sandwiches to be kept in the fridge in the service’s kitchen, but if there was an influx of patients in the evening, these could run out, or be mismatched to a patient’s dietary needs.

We observed some patients eating biscuits and drinking hot drinks early in the evening. We were told that staff were asked to check patient nutrition and hydration needs during hourly rounds. However, we talked with patients in the Fit to Sit area early one morning and they had not been offered any food overnight.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. Staff recorded food and drink that patients had received. We saw some records where fluid balance charts had been requested by medical staff and these had been completed adequately.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain or give pain relief in a timely way.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. However, they did not always check pain and giving pain relief was inconsistent. When a patient’s pain was assessed, staff used a recognised pain scoring tool. We checked with patients in the morning whether anyone had asked if they were in pain. Most replied that this was the case. However, during the evening when the department was busier, about half the patients we spoke to had not been asked about pain.

Patients did not always receive pain relief soon after they requested it or it was identified that they needed it. We saw evidence that in some cases, pain relief was given over an hour after it was prescribed. Staff did not always check the effectiveness of analgesia. We checked records and pain relief appeared to have been recorded accurately.

Patient outcomes

Monitoring of the effectiveness of care and treatment was in development. There was a lack of recent findings for staff to make improvements and achieve better outcomes for patients. The service had no accreditations under relevant clinical accreditation schemes.

The service had a very limited participation in relevant recent national clinical audits. It did not have a comprehensive and systematic audit programme. It had a backlog of incomplete and unprocessed clinical audits. Senior leaders were arranging to review these and bring findings to the emergency department specialty governance meeting, along with new audits based on serious incidents, such as an audit of chest pain.

The service had not performed well in national clinical outcome audits. Previous audits showed the service did not meet standards. In the 2016/17 the Royal College of Emergency Medicine (RCEM) audits for moderate and severe asthma, consultant sign off and the severe sepsis and septic shock, the service at Lincoln failed to meet any of the national standards.

The 2016 Trauma and Research network audit showed that the crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care was higher than the national aggregate but that crude median time from arrival to CT scan of the head for patients with traumatic brain injury took longer than the aggregate. When we inspected we observed that waiting for CT results could also be a long process.
The service participated in the trust’s ward accreditation scheme and scored red overall in April 2019. Individual aspects of care which scored red were paediatrics, environment, infection prevention, falls prevention and nutritional support. Progress on these areas was reviewed at clinical governance meetings.

The service participated in some relevant national clinical audits. It registered for one clinical audit and three quality improvement programmes in 2018/19. In 2018/2019 it had participated in three national Royal College of Emergency Medicine audits, but national reports were not yet available.

Managers were starting to use information from the audits to improve care and treatment. The acute medicine governance meeting and emergency department speciality governance reviewed clinical audits and was starting to ensure that findings and learning were communicated. The service had introduced POPs (paediatric observation priority) assessments but did not have an audit process for this.

The trust planned to share information on audit outcomes. The service completed audits at Grantham on coagulation screening, A&E record keeping, acute kidney injury outcomes and RCEM audit of feverish children. It shared learning across trust hospitals and changed clinical practice where necessary.

The service had similar risk of re-attendance to the England average but above the national standard. Unplanned re-attendance rates to the trust’s emergency departments were in line with the national average between March 2018 and February 2019, at 8%. This is above the national standard of 5%.

Referral to GP streaming was becoming more effective. Re-referrals back to the emergency department from the GP stream reduced form 10.4% in February 2019 to 7.2% in May 2019. Paediatric re-referrals also reduced between the end of May and mid-June.

Competent staff

The service aimed to make sure staff were competent for their roles, but sometimes they did not have the right skills. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly appraisals of their work. From April 2018 to February 2019, 100% of medical staff, 73% of qualified nursing staff and 71% of support staff in the service at Lincoln County Hospital had received an appraisal compared to a trust target of 95%. When we inspected, the matron had six appraisals to do to be up to date.

Managers gave all new staff a full induction tailored to their role before they started work. They reviewed the competencies of agency staff and explained where to find key items such as the resuscitation trolley.

Staff were not always experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were not fully trained for certain competencies. Not enough staff were trained in measuring blood gases, for example. Sepsis training was offered and reviewed but managers recognised that more could be done to reinforce knowledge.

There were operational barriers to improving medical competency. Doctors told us that because of the high proportion of locums, there was an inconsistent understanding of sepsis and it was difficult to find time to have briefing or teaching sessions. They told us that cancellation of planned teaching when the department was busy was also an issue.

However, managers made sure staff received any specialist training for their role. The level of staff paediatric competency was improving, and there was an associated competency framework to
help sustain skills levels. Health Education England supported the service to introduce the Paediatric Observation Priority (POPs) triage and assessment scoring tool. All band seven and six nurses were trained in advanced paediatric life support or similar. Approximately 80% of band five nurses were trained in advanced paediatric life support or similar. For the competency framework, nurses self-assessed then worked through a range of practical situations to demonstrate improvement in their paediatric skills.

There were enough clinical educators to support staff learning and development.

The service did not have regular team meetings unless there was a specific issue to communicate. There was an operational meeting at management level.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

The service worked cooperatively with the patient flow team and bed management team. Bed occupancy at the hospital tended to be high and between 10th and 14th June it varied between 102% and 98%. A band seven flow coordinator worked with wards to identify beds from Monday to Sunday. The hospital held bed meetings several times daily which reviewed number of patients, performance against the 4-hour target, staffing and bed availability. This resulted in plans for individual patients.

The service had improved its arrangements for transferring ambulance patients in which allowed ambulances to be freed up more quickly. The Rapid Assessment and Treatment (RAT) corridor provided swift treatment between 8 am and 6 pm. After this time there was a risk that ambulances would have to queue.

Staff worked well with primary care to stream relevant patients. This was leading to improved response times for patients with minor injuries.

However, the efficiency of processes had never been analysed and teams were not always balanced. We found a doctor on the minors corridor who was unoccupied and not treating patients despite a full waiting room, because the nurse had gone to lunch.

Staff worked across health care disciplines and with other agencies when required to care for patients. (AMSAT).

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. (AMSAT). The mental health liaison team did not attend at night however.

**Seven-day services**

**Not all key services were available seven days a week to support timely patient care.**

Staff could not always call for support from doctors and other disciplines and diagnostic services, including mental health services 24 hours a day, seven days a week. Pharmacy would only dispense drugs on an inpatient drug chart and was open 8:30 to 18:00 most days apart from Sunday when they were open a short time.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service used notice boards around the waiting room and department to promote messages about, for example, healthy living and obesity.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Staff mostly supported patients to make informed decisions about their care and treatment. Not all medical staff had completed mandatory training on this issue. Staff mostly followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

We observed consent arrangements and medical and nursing staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions.
Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients’ records.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was a mental health lead nurse who advised on mental health issues.

Staff assessed mental capacity before investigations or discharge from hospital – if they suspected self-harm they would contact the psychiatric team to do a mental capacity assessment immediately. Mental Capacity Assessment was also a part of End of Life Care planning.

However, in February 2019, less than half of medical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Nearly 86% of nursing staff had completed their training. There was a mental health lead nurse who advised on mental health issues.

Managers did not monitor how well the service followed the Mental Capacity Act.

Lincoln County Hospital

A breakdown of compliance for MCA/DoLS training courses as of February 2019 at Lincoln County Hospital for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>61</td>
<td>71</td>
<td>85.9%</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was not met for the MCA/DoLS training module for which qualified nursing staff were eligible, although the completion rate was above 85%.

A breakdown of compliance for safeguarding training courses as of February 2019 at Lincoln County Hospital for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>5</td>
<td>11</td>
<td>45.5%</td>
<td>90.0%</td>
</tr>
</tbody>
</table>
Is the service caring?

Compassionate care

Staff did not always treat patients with compassion and kindness, respect their privacy and dignity, or take account of their individual needs.

People were not always treated in a kind and considerate way. We observed some patients being spoken to in an off-hand manner at reception when they had just arrived in the department or when they expressed concern about their wait time. Friends and Family test results showed the department scored below the England average when patients were asked whether they would recommend to their Friends and Family.

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was consistently worse than the England average from March 2018 to February 2019.

In the most recent month reported, February 2019, the trust performance was 79.0% compared to the England average of 85.3%.

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

Patient dignity was not always fully respected. This was not facilitated by the layout of the department. We saw a patient who was obviously in a great deal of pain being treated openly in the RAT corridor when staff would have preferred to allocate them to a cubicle, but there were none available.

However, nursing and medical staff were discreet and responsive when caring for patients. They were respectful and considerate. Staff followed the policy to keep patient care and treatment confidential. We observed children being treated in an understanding, kind and sensitive manner.
We observed some very good care of seriously ill patients. In resuscitation we observed a high standard of appropriate and standardised care with early senior involvement, for diabetic ketoacidosis (DKA), heart failure and pancreatitis.

Nursing and medical staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

**Emotional support**

**Staff did not always provide emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.**

Staff did not always give patients and those close to them help, emotional support and advice when they needed it. When we visited one evening, three patients in the department told us they did not know what was happening, what the next stage was, or whether they were likely to stay in hospital overnight. The department did not have a process for supporting patients who had been given bad news, if they attended without friends or relatives.

Staff sometimes supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. (AMSAT). This depended on the patient or their family taking the initiative to request a more private environment.

Not all staff undertook training on breaking bad news and handling difficult conversations. The department did not have a consistent process for supporting patients who had been given bad news, if they attended without friends or relatives. We observed a patient who was not supported after being given news of a serious condition.

However, if patients attended with carers, friends or family members, staff included them in the delivery of patient care and ensured their comfort as much as possible.

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

**Staff did not always supported or involve patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff did not always make sure patients and those close to them understood their care and treatment. In the Emergency Department Survey 2016, the only area in the caring domain where the hospital performed worse than other hospitals was in the patient response to the question ‘If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?’ The responses for the remaining 23 questions were about the same for other trusts.

Staff did not always inform patients about their care in a timely way. We spoke to nine patients in the emergency department and waiting room. When we visited one evening, three patients in the department told us they did not know what was happening, what the next stage was, or whether they were likely to stay in hospital overnight.

Staff supported patients and their families to give feedback on the service where possible, but they told us that in reality they lacked the time to do this.

However, staff talked to patients in a way they could understand, using communication aids where necessary. There was good support for local people whose first language was not English; and the service had staff who spoke Eastern European languages or Portuguese, in addition to
an interpreting service.

Where necessary staff supported patients to make informed or advanced decisions about their care. We observed staff explaining to patients, carers and relatives the choices they had, and they were given time to think and reflect. When we spoke to them they were aware of the decisions available to them.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service was not planned to provide care in a way that met the needs of local people and the communities served. It was starting to work with others in the wider system and local organisations to plan care.

Managers had not planned and organised services to meet the needs of the local population. Services had evolved and did not meet demand. Leaders recognised the need to tailor provision to patient needs. They planned to analyse capacity and demand using an Emergency Care Intensive Support Team (ECIST) modelling tool to improve provision in future. Staff and leaders told us that the service had outgrown its physical environment and the trust was looking at ways of remodelling the premises.

Not all emergency department facilities and premises were appropriate for the service being delivered. There were not enough resuscitation beds, for example. The minors area was regularly used as an overflow area for seriously ill patients but it lacked key equipment essential to their care. The Rapid Assessment and Treatment room was for both sexes so not ideal.

Facilities for mental health patients were not secure. There was no dedicated toilet for mental health patients – they had to use the main toilet in reception which was not ligature proofed. There was a family room which was also used for mental health patients, but the furniture was not secured and could be thrown around. No observation into the family room and there was a notice about breast feeding which would be appropriate for families but not mental health patients. The 136 suite was a clean environment with good furniture. It was not completely ligature proof. If there was more than one patient in the department someone would have to go to an alternative room which did not meet guidelines. There was an unsecured bin in the room which was not needed.

However, the service had made some limited improvements for children. In majors, there was a suitably decorated cubicle for children and there was a small waiting room with toys for very young children next to the main waiting area. There was a separate room for paediatric triage.

During our last inspection we said that the trust should ensure plans to refurbish the quiet room to meet the Psychiatric Liaison Accreditation Network (PLAN) standards. There was now a suitable room with fixed furniture, although not all ligature risks had been removed.

The service had identified that patients nearing end of life were sometimes inappropriately conveyed by ambulance to the emergency department. In the short term they had a room on the RAT corridor which they could quickly convert to an end of life room. In the longer term they wished to develop pathways so that these patients could end their days in a more appropriate setting.

Patients told us that the waiting area had improved because of new seating and the screen which showed wait times. They also commented however that there was nothing to distract patients with a long wait time such as magazines or television.
The service was competently streaming patients to a primary care centre next to the emergency department. This was done mainly by a primary care navigator together with a band six nurse from the trust. Evidence showed a reducing percentage of re-referrals. This showed that the appropriateness of referrals to the GP was improving.

The trust worked with others in the wider health system to plan care including frailty care, same day emergency care and better performance against the four hour emergency care standard, as part of a local urgent and emergency care strategy which would also take services out to the community. Delivery of frailty services was behind schedule when we inspected.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia (AMSAT) The crisis team could attend but there was sometimes a wait of up to three hours.

**Meeting people’s individual needs**

The service was not completely inclusive and did not take account of all patients’ individual needs and preferences. Staff made some reasonable adjustments where possible to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. (AMSAT).

Wards were designed to meet the needs of patients living with dementia.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

The service did not have a comprehensive approach to meeting individual needs. It had not systematically reviewed its services to ensure it met the needs of diverse patient groups. There were no adjustments for people who were deaf or hard of hearing, such as hearing loops. We observed that patient’s names were called when it was time for them to see the nurse, but not all of them heard and there was no visual backup for anyone who had difficulty hearing.

The service did not have arrangements to ensure that patients living with mental health problems, learning disabilities and dementia, consistently received the necessary care to meet all their needs. (AMSAT) While the service had twiddle knits so patients living with dementia could occupy their hands but it did not have butterfly stickers for easy identification or dedicated parking spaces for carers. Staff did not support patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. If patients had learning difficulties, the team tried to treat them quickly but there was no formal procedure in place.

Most staff had not received dementia training. Trust wide plans to improve dementia awareness, treatment and care had not met original deadlines so these arrangements were not yet in place. PLACE survey results for 2018 showed that Lincoln County Hospital had relatively low scores for dementia and disability care.

However, staff had access to communication aids to help patients become partners in their care and treatment. (AMSAT). The service had communication aids to help patients become partners in their care and treatment. There were some pictorial guides so that people with hearing, learning or speaking difficulties which could help communicate basic needs such as for pain relief or the toilet. The trust was rolling out deafness awareness training and staff hoped they would have access to this.

Staff understood and applied the policy on meeting the care needs of patients with a disability or sensory loss. They escalated to matron and offered one to one care.
The service had information leaflets available in languages spoken by the patients and could request translations if needed.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

**Access and flow**

**People sometimes could not access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were below national standards.**

Patients often did not receive treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. In May 2019, at Lincoln 35.8% of patients were seen within 60 minutes of their attendance, so 64.2% were not.

Performance at Lincoln County Hospital on the national four-hour standard was among the worst in the country. After our last inspection published in July 2018, we stated that the trust must ensure all patients who attended the department were admitted, transferred and discharged from the department within four hours. The Department of Health’s standard for emergency departments is that this should happen for 95% of patients. In the first week of June 2019, the service 64% of adult patients were admitted, transferred or discharged within four hours at Lincoln County Hospital, and during our inspection the daily figure varied between 37% and 68%. This was below the trust target of 70.1% and the national target of 95%. Performance for children was generally better and in May 2019 this was 91%.

Managers monitored waiting times but this did not lead to patients receiving services when needed or receiving treatment within agreed timeframes and national targets.

Managers and staff worked to make sure patients did not stay longer than they needed to.

The service validated breaches over four hours and logged the reason for them, but this had not had any impact on service improvement. The most common reasons were ‘ED cubicles full, medical staffing issues, delay in clinician making decision, and unknown delay in ED seeing patient.’ These reasons point to a lack of capacity, staffing and organisation within the department.

The service also measured the percentage of patients who were in the emergency department for less than six hours. This showed a slight improvement. Between 20th May and the week 3rd June this had improved from 73.7% to 77.2% at Lincoln County Hospital. Over the same period there had been an increase from 77.4% to 87% at Pilgrim Hospital Boston.

Patients sometimes waited in the department a very long time between arrival and admission/transfer or discharge. During the week before our inspection, the longest wait for an admitted patient was 19 hours, and for a non-admitted patient 16 hours. We observed patients with a similar wait time during our inspection.

The number of patients leaving the service before being seen for treatments was low.

Flow through the hospital continued to be a challenge for the service. Crowding in the emergency department was still an issue in the evening when there were few alternative pathways for patients. Wards did not release beds in the morning and they often became available after 5 pm. This led to delays in the emergency department because it coincided with when the busiest most crowded time.
Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs (AMSAT).

The full capacity protocol was not always implemented when necessary. Staff were informed about this and could explain it to us. It outlined necessary actions for scenarios for example if there was no space to assess in the emergency department, ambulance waits were greater than 30 minutes or when patients needed admission without empty beds becoming available within an hour. Staff told us they had not used it sufficiently to feel fully competent in its use.

However, the trust had started to tackle unnecessarily long stays and improve flow in its hospitals. In March 2019 it implemented an action plan designed to reduce delayed transfers of care and reduce the number of patients awaiting discharge from hospital more than 48 hours when they were medically fit. In June 2019 it introduced 25 nationally recognised good practice standards for inpatient flow in each ward which included early referral of complex discharges, the SAFER bundle and the Red to Green initiative. When we inspected it was too early to assess the impact of this. In May 2019 there was a reduction in super-stranded patients (over 21 days) in Lincoln, although it was too early to say whether this was sustainable.

The service aimed to improve non-admitted four-hour performance by increasing GP streaming based on the approach at Pilgrim hospital. This was in progress when we inspected, although not at a level to have a noticeable impact on flow. There were pathways to divert patients from the emergency department. GP streaming took approximately 10% of patients between February and May 2019 and the percentage of patients streamed to GP was steadily increasing. The aim was a minimum of 25% streamed patients per day or 50/day and the revised navigation pathway would start from the end of June, with a revised staffing model.

The hospital was developing pathways and services which aimed to avoid admission and speed up treatment. In June 2019 it launched an ambulatory care same day emergency centre. This was led by advanced care practitioners with a consultant. The service aimed to divert from the emergency department up to 25 patients/day with certain day case treatable issues such as deep vein thrombosis, chest pain or cellulitis. There were also plans for a frailty unit which would take admissions from the emergency department, and this would treat specific frailty issues so that patients could return home within 72 hours (3 days). The trust was conducting trials at Pilgrim hospital before setting up arrangements at Lincoln.

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

The number of patients leaving the service before being seen for treatments was comparatively high. From October 2018 to February 2019, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently worse than the England average.

In the most recent month, February 2019, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 5.0%, compared to the England average which was 1.8%.

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

The trust’s monthly median total time in A&E for all patients was consistently higher than the England average from March 2018 to February 2019.

From June 2018 to February 2019 performance against this metric worsened from 186 minutes to 222 minutes. In the most recent month, the median time at the trust was nearly 60 minutes worse than the England average of 165 minutes.
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received most of the time. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Complaints were used as an opportunity for learning. Senior nurses told us that lack of communication about the patient plan and waiting time were frequent complaints. As a result, the service had installed a television monitor in the waiting area to display the waiting times to patients. Local leaders made sure that nurses knew what the plan was for a patient and used SBAR (situation, background, assessment, recommendation) in handovers to the right information was communicated to ensure continuity of care.

Complaints were reviewed at patient experience and clinical effectiveness meetings. The divisional governance support manager planned to meet with consultants to review themes from complaints going back to 2017.

Summary of complaints

A breakdown by site can be seen below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital, Boston</td>
<td>86</td>
<td>47.9%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>73</td>
<td>40.8%</td>
</tr>
<tr>
<td>Grantham &amp; District Hospital</td>
<td>20</td>
<td>11.2%</td>
</tr>
<tr>
<td>Total</td>
<td>179</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Lincoln County Hospital

From March 2018 to February 2019, Lincoln County Hospital received 73 complaints in relation to urgent and emergency care. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>32</td>
<td>43.8%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>10</td>
<td>13.7%</td>
</tr>
<tr>
<td>Values and Behaviour</td>
<td>9</td>
<td>12.3%</td>
</tr>
<tr>
<td>Admission &amp; Discharges (excluding delayed discharge due to absence of a care package)</td>
<td>8</td>
<td>11.0%</td>
</tr>
<tr>
<td>Communication</td>
<td>7</td>
<td>9.6%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>3</td>
<td>4.1%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>2.7%</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>1</td>
<td>1.4%</td>
</tr>
<tr>
<td>Delay in diagnosis</td>
<td>1</td>
<td>1.4%</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Number of compliments made to the trust

From March 2018 to February 2019, there were 1,831 compliments about urgent and emergency care at the trust. A breakdown of compliments by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham Hospital</td>
<td>1,507</td>
<td>82.3%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>137</td>
<td>7.5%</td>
</tr>
<tr>
<td>Pilgrim Hospital Boston</td>
<td>187</td>
<td>10.2%</td>
</tr>
<tr>
<td>Total</td>
<td>1,831</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Is the service well-led?

Leadership

Operationally, leaders had lacked the skills and abilities to run the service. Although they understood and managed the priorities and issues the service faced, they had not been able to find sustainable solutions. Service level leaders were visible and approachable in the service for patients and staff, but trust level leaders were not. Leaders were not always in a position to support staff to develop their skills and take on more senior roles.

There were gaps in leadership at operational level. For example, leadership arrangements for managing deteriorating patients were not fully effective. The emergency practitioner in charge and nurse in charge had oversight of these patients. However, recent incidents showed that the timeliness of interventions varied, and some patients were not fully monitored. Not all clinicians and nurses had the required level of competence to deal with sepsis.

The emergency practitioner in charge (EPIC) role was not fully effective. The protocol for this role was still in draft when we inspected. The aim was to provide overall senior clinical responsibility for the emergency department in line with Royal College of Emergency Medicine guidance between 08:00 and 24:00. The role was intended to ensure safe and effective care, appropriate escalation and achievement of performance standards. This was not happening when we inspected.

The trust did not respond to risks presented by gaps in clinical leadership capacity. When we inspected, no cover arrangements were in place for the clinical lead’s maternity leave. Individual
hospitals in the trust did not have clinical leads at site level, despite the need to clarify organisational arrangements and embed processes.

Trust level leaders were not always visible to patients and staff. Staff told us they rarely saw them. However, urgent care was visibly championed at board level. The full capacity protocol was signed off by the trust board on 5 March 2019. Additionally, a comprehensive risk assessment of ward capacity and environment to comply with the full capacity protocol was led by the director of nursing. The director of nursing, chief operating officer and other senior leaders met with all ward leaders prior to implementation to address challenges and concerns directly with teams.

Senior leaders had the integrity, skills and abilities to run the service. The trust operating model approach led to a new triumvirate leadership team (three senior managers; a nurse, a clinician and an operational manager). Two of the triumvirate members were new and brought change management skills to the service. The team understood and managed the priorities and issues the service faced. For example, they recognised that staff should be more competent to care for and treat children and were addressing this. With the help of ECIST they were working to address sustainability in the medical workforce, and 14 new doctors were due to arrive by the end of August 2019.

Leaders were not always able to support staff to develop their skills and take on more senior roles. There was no succession planning and time for on the job training was limited.

Vision and strategy

The service did not have a specific vision at service level for what it wanted to achieve or a clear strategy to turn it into action, developed with all relevant stakeholders. There were some plans which were aligned to local plans within the wider health economy. Leaders and staff monitored progress against the urgent care programme.

The trust had a vision and a set of values stated in ‘Shaping our future for 2021 and beyond.’ This includes a site level vision for Lincoln County Hospital which included a 24/7 emergency department fronted by an Urgent Care Centre with GP streaming, and a 24/7 paediatric emergency department. This strategy was very new and the extent to which it had been reflected in divisional planning varied.

For the emergency department at Lincoln, strategic planning to turn the vision into action was fragmented and incomplete. The trust had a programme management approach to develop urgent care across the trust which dovetailed with local system partner’s arrangements. However, staff were not clear on what the strategy was, other than the need to recruit doctors and nurses. There was no costed strategy at site level which combined quality and safety improvement, workforce planning and training, meeting the RCEM and RCPCH standards, and meeting the needs of children and the full range of patient’s individual needs.

The trust monitored progress against the urgent care programme but was not on schedule. It was not meeting some of its key targets. The urgent and emergency care continuous improvement plan for Lincoln County Hospital showed trajectories again key performance indicators such as 15 minutes to triage and tracked progress towards key milestones such as training. All eligible nurses were to be competent to do triage by May 2019. The trust measured its progress on the trajectory towards this plan and in May 2019, 4-hour waiting time performance was graded red for admitted and non-admitted patients, with 28.1% of admitted patients waiting less than four hours in A&E at Lincoln.

Some plans partially addressed issues. A new divisional workforce plan aimed to reduce nursing recruitment and retention including the 29.9% (May 2019) vacancy rate in the emergency department for qualified nurses. Leaders had surveyed staff as part of the planning process. Some
of the retention policies included ‘retire and return’ internal transfers and flexible working. However, this did not include a long-term approach to nursing training and education. There were some trust wide action plans aimed at addressing issues of quality. This included reducing the incidence of falls in the emergency department through better identification of people vulnerable to falls.

**Culture**

Staff did not always feel respected, supported and valued. They were, however, focused on the needs of patients receiving care. The service was starting to develop an open culture where patients, their families and staff could raise concerns without fear.

Staff did not always feel respected, supported and valued. They told us this and many were frustrated that the service had not overcome all of its performance issues and appeared to be reactive rather than strategic. The service had not conducted a cultural audit, so it did not know which aspects of culture it could positively address. Some staff were demotivated by staffing issues and the lack of consultant cover.

Staff were mostly loyal to the trust, keen to deliver good care, and be part of a high performing service. However, long waits and below average performance had become the norm. There was a need to raise awareness of what good looked like.

The service carried out appraisals which identified career development. In practice, development was constrained by staffing needs.

Staff were focused on the needs of patients receiving care. There was not a strong emphasis on the safety and wellbeing of staff, other than providing items such as snacks and tissues in the staff room. Leaders recognised this and planned a meeting with human resources to take action on staff wellbeing.

The service was in the early stages of developing an open culture where patients, their families and staff could raise concerns without fear. The trust operating model aimed to promote new values, including plans to inform, consult, engage and empower staff.

**Governance**

Leaders did not consistently operate effective governance processes in the service. However, joint governance of primary care streaming in the emergency department worked well. Staff at all levels were clear about their roles and accountabilities but processes to meet, discuss and learn from the performance of the service were in development.

At service level, governance processes were not sufficiently effective to ensure that the service was always safe or performed well. The emergency department weekly operations meeting did not regularly review a performance and quality dashboard, and the agenda was informal. They investigated incidents such as a child with a high PEWS score not having access to a paediatric cubicle, however, showing that they reviewed learned from incidents.

The trust was starting to improve governance processes, but these were not fully embedded. The new trust operating model aimed to standardise processes and empower staff. The department and the division had new meetings, structures and responsibilities. Some roles and responsibilities had yet to be clarified, for example the EPIC consultant role in the emergency department.

Processes to learn in response to serious incidents were becoming more timely. Minutes of May’s Patient Experience and Clinical Effectiveness meeting showed that the department learned from incidents for example, developing a standard operating procedure for chest x-rays. Training was offered to ensure that all consultants knew how to do a good quality mortality review to strengthen
learning from this. Senior managers presented incidents to the risk team at rapid review process meetings twice a week, before they were discussed at clinical governance meetings.

In addition to routine governance processes, the trust had governance arrangements to manage the improvement and re-design of emergency care at Lincoln and across the trust. This included an UEC Recovery Steering Group, and a UEC delivery group which reported to the Executive weekly. Milestones completed so far included the review and development of standard operating procedures for the Rapid Assessment and Treatment area (RAT).

Staff at all levels were clear about their roles and accountabilities.

Leaders operated effective governance processes with partner organisations. The Integrated Urgent Care Governance meeting met monthly and was chaired by local commissioners. This meeting monitored and acted on quality issues such as clinical governance and safety, complaints and the developments such as the future minor injuries service model.

**Management of risk, issues and performance**

Leaders and teams had not used systems to manage performance effectively. They were starting to identify and escalate relevant risks and issues and identified actions to reduce their impact. They had some plans to cope with unexpected events. There were limited safeguards to avoid cost saving decisions compromising the quality of care.

There was a track record of ineffective performance management. Performance in the emergency department had been below average for a long time without resolution. Staff told us that leaders were not held to account for this.

At service level, performance monitoring was not always used effectively. Although the service monitored the reasons for breaches over four hours, this did not lead to action to solve problems. The department's operations meeting did not include a quality dashboard or performance monitoring against targets. This meant that trends or dips in performance were not always reviewed in a timely way.

Use of review processes to inform performance improvement was limited. There was no comprehensive programme of internal and external audit. There was no management culture of self-assessment against standards such as RCPCH or other best practice guidance.

Monitoring by strategic groups such as the Urgent Care Steering group did not necessarily result in prompt action. The trajectory identified required trust wide 4-hour target performance levels of 70% to 73% from April to June 2019. The national standard is 95%. In May, performance reached 68%. There was no specific plan to get this back on track. The review of the May 2019 Urgent Care Programme dashboard did not show how performance shortfalls would be put right, other than increasing GP streaming for minors patients.

The service lacked a standardised impact assessment approach to measure the impact of cost saving changes due to financial pressures on the quality of service.

However, assurance systems were starting to strengthen due to new governance arrangements brought in by the trust operating model. The divisional triumvirate had to review performance in detail with the senior leadership team at a Performance Review MS meeting.

The risk management process was still in the process of being rationalised. The divisional performance pack identified risks such as rota coordination, administrative capacity, medical staff rotas, sepsis and triage, continued overcrowding and ambulance handovers as the major risks. Action on risks was not always timely or effective. The Risk Register 2019 identified key financial quality and safety risks such as heavy reliance on agency and locums, shortage of cubicles to
provide privacy, reliance of locum middle grade doctors, imbalance between demand and capacity, shortfall of deanery junior doctors, inadequate staffing, and lack of strategy for children. Staff shortages and dependence on locums had been risks for a long time but had not been resolved.

Information management

The service did not always collect reliable information. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems in the department were not integrated. Data or notifications were consistently submitted to external organisations as required.

Arrangements to ensure data quality was consistent were not yet in place. Data collection in the emergency department at Lincoln County hospital was not always reliable. Triage was monitored from the first contact with the healthcare assistant rather than from the triage decision. We also observed some confusion about measuring length of stay if it happened to be over 12 hours. The trust had a data quality assurance group but was still establishing links with services.

The service did not have holistic view of performance although this was improving. It had a detailed performance pack for review at divisional level. This included financial, workforce, quality and performance but did not include patient feedback, or separate analysis for children and adults. We reviewed a medicines performance pack for the 28th June which showed that the service was tackling inconsistent management of sepsis and diabetic ketoacidosis (DKA) and was introducing shift sepsis leads. These issues had been highlighted by our inspection but also by ward accreditation reporting arrangements.

Performance was not regularly reviewed at operational level. The service recognised this was bringing in a dashboard to be monitored at the weekly operational meeting.

Some information systems at service level were not integrated and did not improve care. Staff told us there was a problem allocating patients in the RAT area to a cubicle on their IT system. There had also been a problem with individual staff understanding how to complete the sepsis screen, which led to incorrect records.

The service had a helpful display screen which showed where patients were in the department, their risks and key observations. This helped staff identify patients and respond quickly.

There were effective arrangements to ensure that externally required data and notifications were reliable and submitted in a timely way.

Engagement

Leaders and staff had not actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. This was beginning to change. They did however, work with local system partner organisations to help improve services for patients.

Staff had not been routinely surveyed for their views or engaged in continuous improvement. When we asked, staff could not think of an improvement which would make a difference to patients which had happened because of a staff suggestion. Staff had not been consulted about strategic plans.

However, the new triumvirate had asked staff for their views and they did not have a high opinion of the service. Engagement meetings were starting to take place and took place, for example to discuss the full capacity protocol and were planned to discuss potential changes to the minors area.
Feedback from patients was limited because staff lacked the time to ask patients. However, the service had responded to patient requests for more information by providing a screen in the waiting area which gave patients the length of wait time. During our inspection, we found that the screen worked intermittently.

The service was working with commissioners to improve access to emergency care. This had led to primary care streaming with plans to develop this further.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services and were involving outside agencies in making improvements. However, they did not have a good understanding of quality improvement methods and the skills to use them. With some exceptions the department did not have a track record of encouraging innovation and participation in research.

Processes and pathways within the emergency department at Lincoln had not been analysed to identify inefficiencies or opportunities for process re-design. The service did not have standardised improvement tools and methods.

The service had not systematically benchmarked its processes with the best performing urgent care services, but leaders were starting to visit services which they could learn from.

However, the trust evaluated its major projects to capture learning. We saw the post implementation review for the Pilgrim hospital re-configuration. This was intended to inform the Lincoln County Hospital reconfiguration and highlighted the need to have a dedicated nurse manager running the workforce side of changes, and to involve advanced care practitioners more than at Boston. The trust had learnt from the lack of engagement, wrong levels of staffing, and difficulties of training staff who were not in place at Boston.

The trust introduced an Integrated Assessment Centre at Pilgrim Hospital which increased same day treatment by 15% and hoped to transfer lessons learned and good practice to Lincoln County Hospital.
Medical care (including older people’s care)

Facts and data about this service

The trust provides medical care (including older people’s care) at three sites: Grantham and District Hospital; Lincoln County Hospital; and Pilgrim Hospital. Services at all sites sit within the division of medicine and are managed through the cardiovascular and specialty medicine clinical business units.

The trust has 546 inpatient medical beds across Lincoln County Hospital and Pilgrim Hospital, with 300 of these beds being located at Lincoln County Hospital.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 72,242 medical admissions from January to December 2018. Emergency admissions accounted for 33,181 (45.9%), 1,269 admissions (1.8%) were elective, and the remaining 37,792 (52.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 31,313 admissions
- Clinical haematology: 7,985 admissions
- Clinical oncology: 7,447 admissions

(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 service mostly made sure all staff completed mandatory training in key skills. The number of staff who completed it did not meet trust targets in all training modules.

Mandatory training completion rates

Nursing and medical staff received and kept up to date with most of their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

The trust set a target of 90% for completion of mandatory training, with the exceptions of:

- Fraud awareness and infection prevention level one, which had targets of 95%.
- Local fire procedures and fire safety, which had targets of 100%.
- Immediate life support (ILS)/advanced life support (ALS) and medicine management training which had no targets. The trust informed us that the eligible numbers of staff were not available for these two courses and therefore we were unable to calculate completion rates.

Trust level

A breakdown of compliance for mandatory training courses as of February 2019 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; safety</td>
<td>604</td>
<td>622</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>602</td>
<td>622</td>
<td>96.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>601</td>
<td>622</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>593</td>
<td>622</td>
<td>95.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>584</td>
<td>622</td>
<td>93.9%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>584</td>
<td>622</td>
<td>93.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>569</td>
<td>622</td>
<td>91.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>562</td>
<td>622</td>
<td>90.4%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>540</td>
<td>622</td>
<td>86.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>538</td>
<td>622</td>
<td>86.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>533</td>
<td>622</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>269</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>111</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

In medicine, the target was met for four of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.
A breakdown of compliance for mandatory training courses as of February 2019 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>103</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>103</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>102</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>101</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>98</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>97</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>91</td>
</tr>
<tr>
<td>Fire safety</td>
<td>90</td>
</tr>
<tr>
<td>Information governance</td>
<td>87</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>86</td>
</tr>
<tr>
<td>Basic life support</td>
<td>71</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>6</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>5</td>
</tr>
</tbody>
</table>

In medicine, the target was met for four of the 11 applicable mandatory training modules for which medical staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

**Lincoln County Hospital medicine department**

A breakdown of compliance for mandatory training courses as of February 2019 for qualified nursing staff in the medicine department at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>327</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>327</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>325</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>320</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>316</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>316</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>311</td>
</tr>
<tr>
<td>Fire safety</td>
<td>307</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>299</td>
</tr>
<tr>
<td>Information governance</td>
<td>298</td>
</tr>
<tr>
<td>Basic life support</td>
<td>297</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>163</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>60</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital medicine department, the target was met for four of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

A breakdown of compliance for mandatory training courses as of February 2019 for medical staff in the medicine department at Lincoln County Hospital is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; safety</td>
<td>61</td>
<td>62</td>
<td>98.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>61</td>
<td>62</td>
<td>98.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>60</td>
<td>62</td>
<td>96.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>59</td>
<td>62</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>58</td>
<td>62</td>
<td>93.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>58</td>
<td>62</td>
<td>93.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>56</td>
<td>62</td>
<td>90.3%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>54</td>
<td>62</td>
<td>87.1%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>51</td>
<td>62</td>
<td>82.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>50</td>
<td>62</td>
<td>80.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>42</td>
<td>62</td>
<td>67.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>1</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>3</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital medicine department, the target was met for four of the 11 applicable mandatory training modules for which medical staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

There was clear guidance for staff which outlined what mandatory training was required for their roles. Staff received mandatory training through face-to-face sessions and e-learning modules. Staff understood their responsibility to complete mandatory training. It was the responsibility of individual ward managers to monitor mandatory training and alert staff when they needed to update their training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning, disabilities, autism and dementia.

There was a sepsis E-learning package for staff to complete which covered recognising adults and children with sepsis as well as neutropenic sepsis. In addition to the E-learning, the lead sepsis nurse practitioner would attempt to visit all wards two to three times a week and deliver additional training if staff requested it. Each ward also had its own sepsis box.

Medical wards used the national Sepsis 6 pathway of care bundle. There was a sepsis practitioner based on the hospital site that worked to improve compliance with initial screening and antibiotics administration within the first ‘golden’ hour of recognition.

On our previous inspections we there was a need to improve staff training compliance. This was a long-term challenge due staffing on each ward. We did however find evidence in each clinical area that training compliance had improved. Clinical nurse educators and matrons supported ward teams to access training despite increasing pressure on services.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had completed mandatory training on how to recognise and report abuse.

**Safeguarding training completion rates**
Nursing and medical staff received training specific for their role on how to recognise and report abuse.

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

**Trust level**

A breakdown of compliance for safeguarding training courses as of February 2019 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>558</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>557</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>535</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>534</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>2</td>
</tr>
</tbody>
</table>

In medicine the 90% target was not met for any of the five safeguarding training modules for which qualified nursing staff were eligible. However, the completion rates for the safeguarding adults and children level 1 modules were only slightly below the target.

A breakdown of compliance for safeguarding training courses as of February 2019 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>94</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>94</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>88</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>88</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met not for any of the four safeguarding training modules for which medical staff were eligible.

The trust had a policy and procedure in place to safeguard children and vulnerable adults at risk. Policies were available to staff on the intranet and staff knew how to access them when required.

Nursing staff were aware of the signs of abuse including action to take when they suspected or confirmed female genital mutilation (FGM). They told us they would report any concerns to the person in charge of the shift or the ward manager. Staff were aware how to make a safeguarding referral to the local authority and would seek support from the safeguarding leads if necessary.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

**Lincoln County Hospital medicine department**
A breakdown of compliance for safeguarding training courses as of February 2019 for qualified nursing staff in the medicine department at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>299</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>298</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>289</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>288</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital medicine department, the 90% target was met for one of the five safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of February 2019 for medical staff in the medicine department at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>54</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>54</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>52</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>52</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital medicine department, the 90% target was not met for any of the four safeguarding training modules for which medical staff were eligible.

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

### Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained.

There was an infection prevention and control standard in use for the prevention of meticillin resistant staphylococcus aureus (MRSA). Only specific patient groups were screened.

Quarterly decontamination audits of endoscopic equipment took place in line with national standards and as required by Joint Advisory Group (JAG) accreditation guidelines. Staff told us that there was no shortage of equipment that would prevent them from delivering the service.

The infection prevention and control team met monthly and discussed organisational, training and education issues. The learning and education team were rolling out new training for aseptic non touch technique (ANTT).

During our inspection we observed staff demonstrate good adherence to hand hygiene practices. Staff were seen washing their hands with soap and water and using antibacterial hand gel.
also saw appropriate use of personal protective equipment (PPE) including gloves and aprons. From June 2018 to May 2019 the trust scored between 75% to 100% on hand hygiene audits.

A piece of work was undertaken by the trust between January and March 2019 (quarter four) which changed the way in which hand hygiene was assessed. Prior to this the trust would receive consistent 100% hand hygiene compliance in most areas and recognised that this probably did not reflect actual practice. The trust therefore changed the hand hygiene assessment methodology to better reflect a more accurate position and to show the areas where non-compliance needed support. During quarter four, the infection prevention and control (IPC) team briefed the trust IPC committee to advise that they expected hand hygiene numbers to decline as the new assessment tool was rolled out. This guided the IPC team on where they needed to focus their efforts to support improvements.

Lever operated taps were in place at most hand wash basins, with liquid soap dispensers and paper hand-towels nearby. This was in line with Health Building Note (HBN) 00-09.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment was dated with “I am clean” stickers. This enabled staff to instantly recognise when equipment was last cleaned

Side rooms were available for patients who required isolation due to clinical conditions. We saw that there was appropriate signage to encourage staff and visitor to wear PPE or speak to the nurse in charge for information before entering the rooms. We saw doors for side rooms with isolated patients were kept closed. Most side rooms had toilet facilities. Staff told us deep cleans were arranged following the discharge of patients from side rooms. On Navenby Ward we saw staff educating visitors and explaining why PPE had to be worn and that this should be removed prior to leaving the patients room and disposed of in the appropriate bin.

Staff followed infection control principles including the use of personal protective equipment (PPE). Standards of cleanliness and hygiene were generally well maintained, and all areas we inspected were visibly clean and generally tidy. However, the service score for cleanliness was worse than the England average score for cleanliness, of 99%, in the patient-led assessment of the care environment (PLACE). In this assessment the hospital scored 94.8% in 2018.

A piece of work was undertaken by the trust between January and March 2019 (quarter four) which changed the way in which hand hygiene was assessed. Prior to this the trust would receive consistent 100% hand hygiene compliance in most areas and recognised that this probably did not reflect actual practice. The trust therefore changed the hand hygiene assessment methodology to better reflect a more accurate position and to show the areas where non-compliance needed support. During quarter four, the infection prevention and control (IPC) team briefed the trust IPC committee to advise that they expected hand hygiene numbers to decline as the new assessment tool was rolled out. This guided the IPC team on where they needed to focus their efforts to support improvements.

Hand sanitising gel dispensers were readily available throughout clinical areas. Posters were situated outside the entrances to some wards. These posters prompted staff and visitors to maintain effective hand hygiene to prevent the spread of infection. The hand gel was located on the exterior side of the entry doors to the ward, meaning that hands could become contaminated on entry. The availability of hand sanitising gel at the entrance of the wards were inconsistent these were not seen on all wards we visited during our inspection.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.
The service did not always have enough suitable equipment to help them to safely care for patients. Staff on some wards shared equipment between other wards. This included drip stands, fluid pumps and bladder scanners.

On Carlton-Colby ward there was limited space within the bays around the beds for patients that required non-invasive ventilation (NIV). Senior nurses would do daily bay inspections to ensure that the bed spaces were clean and de-cluttered to ensure there was a safe enough space for additional equipment some patients required.

The design of the environment followed did not always follow national guidance. There was a recent flood on Scampton ward which staff told us they felt they had responded to well by evacuating eight patients and arranging them to be nursed on other wards. The patients had later returned to the ward however, the roof was still waiting to be fixed. This was escalated to matrons, site manager and facilities.

The chemotherapy unit consisted of 22 chairs. At the time of our inspection all 22 chair were in use. The unit appeared very crowded and the unit was limited in how to create privacy for patients due to the lack of space.

Most equipment we saw had been safety tested; stickers on equipment confirmed this had been completed with the date of next date due detailed on the sticker.

Patients could reach call bells and staff responded quickly when called.

Staff disposed of clinical waste safely. Staff complied with DH Health Technical Memorandum (HTM) 07/01 in relation to the Safe Management and Disposal of Healthcare Waste (2013). Waste was appropriately segregated in clinical areas with separate colour coded arrangements for general waste, clinical waste and sharps (needles). Bins were clearly marked, were pedal operated and within safe fill limits.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys containing medicines and equipment required in an emergency were accessible on all wards we visited. They were safely secured with tamper proof seals. The resuscitation trolleys we looked at during our inspection were checked daily and weekly to ensure they were stocked, equipment was in working order and medicines were up to date.

During our inspection we saw pressure mattresses and bariatric equipment in use around the hospital and staff told us these were readily available when needed. Navenby ward had a specially designed side room for bariatric patients, there was extra space around the bed and there was a fitted bariatric ceiling hoist. There was also toilet and hygiene facilities within the room suitable for use by bariatric patients. Screens had been put in place between the bed area and toilet to ensure that the patient dignity was maintained.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and acted to remove or minimise risks. Staff did not always immediately identify and act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patient observations were recorded electronically and NEWS2 was implemented across all wards. When patients had a NEWS2 score above five the sepsis lead nurse would be notified electronically. In addition, the critical outreach team (CCOT) were also notified through the electronic system. Most staff we spoke to were generally positive about how responsive the clinical teams who assess deteriorating patients were when they had a raised NEWS2.
Staff knew about and dealt with any specific risk issues however, staff did not always respond within the expected timescale. We reviewed three sets of inpatient notes who had triggered for sepsis. One patient did not receive their dose of antibiotics within the recommended one hour of triggering for sepsis. The antibiotics were prescribed within the hour but not administered. All patients had a completed sepsis care bundle and their observations frequency increased for more regular monitoring.

The trust provided us with data from their monthly sepsis audit. Between March 2019 and May 2019 the percentage of inpatients who had been screen for sepsis was variable across all the medical wards. Between 57% and 100% were screened due to an increased National early warning score (NEWS2), within the same time frame on March 2019 to May 2019 between 50% and 100% of patients received intravenous (IV) antibiotics within 60 minutes of being screened.

Medical staff told us that a limited amount of specialist consultants would routinely visit MEAU. If the referral was not made promptly in the morning, patients were often not seen until the next day.

There were onsite critical care beds for patients that had deteriorated and required closer monitoring and further intervention. This included full ventilator support. The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient’s mental health.

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.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Every ward had a ligature risk assessment, we reviewed one assessment and found it to be thorough and detailed. The risk assessment included steps taken to mitigate risks, each bay and side room were individually risk assessed.

Chemotherapy spillage kits were visible on Ingham ward and staff knew how to use them.

We spoke to staff on Navenby ward and the care given to diabetic patients, they told us that diabetic nurses were available Monday to Friday between 8am and 4pm, they regularly visited the ward and provided support for patients and staff in the care and treatment of diabetic patients. Patients with Diabetic Ketoacidosis (DKA) were only cared for on MEAU.

All staff on Waddington ward were trained to administer intravenous (IV) antibiotics as a patient group directive (PGD) when they were displaying symptoms of neutropenic sepsis. A PGD provides a legal framework that allows registered health professionals who have completed the competency to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber.

The endoscopy unit was open seven days a week, up until at least 6pm. Staff told us that this would be later if there were emergencies.

There was a Resuscitation and Deteriorating Patient Policy that could be accessed by staff via the trust intranet.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. Patient risk assessments included falls risk assessments, body mapping as part of the SSKIN bundle and nutrition and frailty risk assessments. Risk assessments were repeated at regular intervals according to the patients’ clinical condition.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe.
Nurse staffing

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The service did not always have enough nursing staff of all grades to keep patients safe. On Carlton Colbey staff told us that they had two non-invasive ventilation (NIV) trained nurses on duty in the day but only one at night. They had recently experienced a shift where there was five patients that required NIV so additional staff were taken from other wards to provide extra support. NIV refers to the administration of ventilatory support through the patient’s upper airway using a mask or similar device without having to use an invasive artificial airway.

The number of nurses and healthcare assistants on all shifts on each ward did not always match the planned numbers.

There were full team daily handovers amongst ward nursing staff, some wards did a bedside handover at the start of each shift. On one ward we saw accountability sheets used at handover. Both the nurse going off shift and the one starting their shift signed to say that they had received accurate information and that documentation was in place.

The ward manager could adjust staffing levels daily according to the needs of patients.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. In accordance with national guidance.

Trust level

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for medical care.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>County Hospital Louth</td>
<td>5.5</td>
<td>6.3</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>55.2</td>
<td>70.7</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>289.3</td>
<td>345.7</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>149.2</td>
<td>202.2</td>
</tr>
<tr>
<td>Pan trust*</td>
<td>23.9</td>
<td>24.9</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>523.0</td>
<td>649.8</td>
</tr>
</tbody>
</table>

* The trust informed us that some staff worked over multiple sites. These staff are included under ‘pan trust’ above.

From April 2017 to March 2018, the nursing staffing rate within medicine was 80.5%. This was similar to the rate of 81.2% in the more recent period from April 2017 to February 2019.

Fill rates greater than 100% indicate there were more WTE in post than originally planned.

Lincoln County Hospital

Lincoln County Hospital reported the following WTE nursing staff numbers for the periods below for medicine. There are 26 units within medicine at this location so the five with the lowest fill rates in the later time period have been included, along with the total for all 26 units.
<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th>April 2018 to February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
<td>Staffing rate (%)</td>
<td>Actual staff</td>
<td>Planned staff</td>
<td>Staffing rate (%)</td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Emergency assessment unit</td>
<td>36.0</td>
<td>38.3</td>
<td>94.0%</td>
<td>35.4</td>
<td>49.3</td>
<td>71.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frailty assessment unit</td>
<td>9.8</td>
<td>15.5</td>
<td>62.9%</td>
<td>11.0</td>
<td>15.5</td>
<td>70.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lancaster Ward</td>
<td>10.5</td>
<td>14.7</td>
<td>71.1%</td>
<td>9.7</td>
<td>14.7</td>
<td>65.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scampton Ward</td>
<td>8.8</td>
<td>14.7</td>
<td>60.1%</td>
<td>9.5</td>
<td>14.7</td>
<td>64.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical haematology inpatients</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0.0</td>
<td>1.0</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Site total</strong></td>
<td><strong>289.3</strong></td>
<td><strong>345.7</strong></td>
<td><strong>83.7%</strong></td>
<td><strong>307.7</strong></td>
<td><strong>352.9</strong></td>
<td><strong>87.2%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the nursing staffing rate within medicine at Lincoln County Hospital was 83.7%. This was lower than the rate of 87.2% in the more recent period from April 2018 to February 2019.

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

### Vacancy rates

#### Trust level

From April 2018 to March 2019, the trust reported a vacancy rate of 21.2% for nursing staff in medicine. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital medicine department: 17.4%
- Pilgrim Hospital medicine department: 32.6%

A breakdown of the five highest vacancy rates by ward at each site is below:

#### Lincoln County Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical haematology inpatients</td>
<td>66.7%</td>
</tr>
<tr>
<td>Scampton Ward</td>
<td>36.3%</td>
</tr>
<tr>
<td>Lancaster Ward</td>
<td>35.9%</td>
</tr>
<tr>
<td>Frailty assessment unit</td>
<td>32.0%</td>
</tr>
<tr>
<td>Navenby Ward</td>
<td>30.2%</td>
</tr>
</tbody>
</table>

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

### Turnover rates

#### Trust level

From April 2018 to March 2019, the trust reported a turnover rate of 7.4% for nursing staff in medicine. This was lower than the trust target of 8%.

- Lincoln County Hospital medicine department: 7.0%
- Pilgrim Hospital medicine department: 6.4%

A breakdown of turnover rates by ward for each site is below.

#### Lincoln County Hospital
Twelve of the 25 medical wards/departments had turnover from April 2018 to March 2019. The five wards with the highest turnover are shown below:

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastro nurse specialists</td>
<td>59.2%</td>
</tr>
<tr>
<td>Oncology clinical nurse specialists</td>
<td>31.7%</td>
</tr>
<tr>
<td>Ingham Ward</td>
<td>17.5%</td>
</tr>
<tr>
<td>Medical day unit</td>
<td>17.4%</td>
</tr>
<tr>
<td>Johnson Ward</td>
<td>14.8%</td>
</tr>
</tbody>
</table>

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

Sickness rates

Trust level

From April 2018 to March 2019, the trust reported a sickness rate of 4.7% for nursing staff in medicine. This was higher than the trust target of 4.5%.

- Lincoln County Hospital medicine department: 4.4%
- Pilgrim Hospital medicine department: 4.4%

A breakdown of the five highest sickness rates by ward for each site is below.

Lincoln County Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical day unit</td>
<td>20.7%</td>
</tr>
<tr>
<td>Ingham Ward</td>
<td>7.6%</td>
</tr>
<tr>
<td>Ashby Ward</td>
<td>7.4%</td>
</tr>
<tr>
<td>Dixon Ward</td>
<td>6.7%</td>
</tr>
<tr>
<td>Frailty assessment unit</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

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

Bank and agency staff usage

The service had high rates of bank and agency nurses used on the wards.

Due to high vacancy rates it was challenging for managers to limit their use of bank and agency Staff. Requested staff familiar with the service were not always requested.

Trust level

The table below shows the numbers and percentages of nursing hours in medicine at trust level from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 1,328,038 total working hours available, 8.2% were filled by bank staff and 13.6% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 6.3% of the available hours with either bank or agency staff.

Of the 742,665 total working hours available, 26.0% were filled by bank staff and 0.3% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.
In the same period, the trust was not able to fill 3.0% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
</tr>
<tr>
<td></td>
<td>Hrs</td>
</tr>
<tr>
<td>Qualified staff</td>
<td>1,328,038</td>
</tr>
<tr>
<td>Non-qualified staff</td>
<td>742,665</td>
</tr>
<tr>
<td>Total</td>
<td>2,070,703</td>
</tr>
</tbody>
</table>

Lincoln County Hospital

The tables below show the number and percentage of nursing hours in medicine at Lincoln County Hospital from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Qualified nursing staff

Of the 779,566 total working hours available, 7.6% were filled by bank staff and 11.7% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 3.8% of the available hours with either bank or agency staff.

The five departments with the highest numbers of combined bank, agency and unfilled hours are shown in the table below. The negative figure for Waddington Unit indicates that additional hours were rostered over and above the set establishment.

<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
</tr>
<tr>
<td></td>
<td>Hrs</td>
</tr>
<tr>
<td>MEAU Ward</td>
<td>96,460</td>
</tr>
<tr>
<td>Johnson Ward</td>
<td>93,801</td>
</tr>
<tr>
<td>Carlton Coleby Ward</td>
<td>43,240</td>
</tr>
<tr>
<td>Waddington Unit</td>
<td>49,354</td>
</tr>
<tr>
<td>Frailty Assessment Unit</td>
<td>30,348</td>
</tr>
<tr>
<td>Core service total</td>
<td>779,566</td>
</tr>
</tbody>
</table>

Non-qualified nursing staff

Of the 391,421 total working hours available, 27.7% were filled by bank staff and 0.3% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 1.2% of the available hours with either bank or agency staff.

The five departments with the highest numbers of combined bank, agency and unfilled hours are shown in the table below. The negative figure for Dixon indicates that additional hours were rostered over and above the set establishment.
### Table: Staffing Levels and Comparison

<table>
<thead>
<tr>
<th>Ward/Unit</th>
<th>Available Hrs</th>
<th>Available %</th>
<th>Bank or Agency Hrs</th>
<th>Bank or Agency %</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEAU Ward</td>
<td>42,921</td>
<td>14,338</td>
<td>116</td>
<td>0.3%</td>
</tr>
<tr>
<td>Dixon Ward</td>
<td>29,957</td>
<td>11,620</td>
<td>212</td>
<td>0.7%</td>
</tr>
<tr>
<td>Carlton Coleby Ward</td>
<td>28,445</td>
<td>9,689</td>
<td>168</td>
<td>0.6%</td>
</tr>
<tr>
<td>Scampton Ward</td>
<td>26,828</td>
<td>8,845</td>
<td>87</td>
<td>0.3%</td>
</tr>
<tr>
<td>Frailty Assessment Unit</td>
<td>31,286</td>
<td>8,162</td>
<td>51</td>
<td>0.2%</td>
</tr>
<tr>
<td>Core Service Total</td>
<td>391,421</td>
<td>108,311</td>
<td>1,095</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

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

The planned levels of staff and the actual levels were displayed on each ward/unit and updated daily. We reviewed these during the inspection and discussed the staffing levels with the nurses in charge. Safer nurse staffing levels during the inspection were below planned levels on numerous wards across the medicine division. For example, on one day during our inspection Lancaster ward were working with reduced staffing, one registered nurse gap was filled by agency and for health care assistance they had relied on using staff from other wards, but this was only for a short period of time.

Staff were often redeployed from other areas of the hospital to keep staffing number safe. Staff we spoke felt that this had an impact on staff morale as they would often be moved. Staff also felt that at times there wasn’t enough nurses to keep people safe.

The use of agency staff helped to cover staffing numbers however, some were unfamiliar with the ward areas and did not always have the skills and knowledge required to to give safe care. This created extra pressure on to those that were familiar with the work. Staff we asked were not always aware if agency staff had received an induction. Not all managers made sure all bank and agency staff had a full induction and understood the service.

Agency nurses were required to provide evidence of competencies or certification for administering intravenous medicine.

There were systems and processes in place to assess, plan and review staffing levels, including staff skill mix. A staffing tool was used to calculate the number of nurses and health care assistants required for each shift based on the needs and level of care patients required.

### Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patient’s safe from avoidable harm and to provide the right care and treatment.

The service did not have enough medical staff to keep patients safe.

On MEAU consultants worked from 12 to 12. They left the unit at 9pm when there was overnight consultant cover available via an on-call service. Staff reported that they had not ever experienced a delay in getting a consultant to see patients overnight if this was required.

On MEAU they there was a daily ward round at 8am between night and day consultants, registrars and junior doctors as well as the nurse in charge on the day shift. They reviewed the patients that were admitted overnight first, secondly patients in the step-down bay followed by the rest of the patients on the ward.

### Trust level
The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for medicine.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>27.2</td>
<td>38.2</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>111.9</td>
<td>128.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>62.8</td>
<td>69.0</td>
</tr>
<tr>
<td>Pan trust*</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>202.8</td>
<td>236.2</td>
</tr>
</tbody>
</table>

* The trust informed us that some staff worked over multiple sites. These staff are included under ‘pan trust’ above.

From April 2017 to March 2018, the medical staffing rate within medicine was 85.9%. This was higher than the rate of 78.8% in the more recent period from April 2018 to February 2019.

**Lincoln County Hospital**

Lincoln County Hospital reported the following WTE medical staff numbers for the periods below for medicine. There are 11 units within medicine so the five with the lowest fill rates have been included, along with the total for all 11 units.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Clinical oncology inpatients</td>
<td>18.0</td>
<td>18.0</td>
</tr>
<tr>
<td>Elderly care inpatients</td>
<td>9.1</td>
<td>22.5</td>
</tr>
<tr>
<td>Acute medicine</td>
<td>24.0</td>
<td>9.9</td>
</tr>
<tr>
<td>Clin haematology inpatients</td>
<td>7.1</td>
<td>10.5</td>
</tr>
<tr>
<td>Stroke inpatients</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Site total</strong></td>
<td>111.9</td>
<td>128.0</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the medical staffing rate within medicine at Lincoln County Hospital was 87.4%. This was higher than the rate of 81.8% in the more recent period from April 2018 to February 2019.

Figures higher than 100% indicate there were more WTE in post than originally planned.

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

**Vacancy rates**

**Trust level**

From April 2018 to March 2019, the trust reported a vacancy rate of 17.8% for medical staff in medicine. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital medicine department: 16.2%
- Pilgrim Hospital medicine department: 17.6%

A breakdown of the five highest vacancy rates by ward for each site is below:

**Lincoln County Hospital**
<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke inpatients</td>
<td>52.4%</td>
</tr>
<tr>
<td>Acute medicine</td>
<td>42.7%</td>
</tr>
<tr>
<td>Clin haematology inpatients</td>
<td>33.5%</td>
</tr>
<tr>
<td>Elderly care inpatients</td>
<td>25.1%</td>
</tr>
<tr>
<td>Respiratory medicine inpatients</td>
<td>24.6%</td>
</tr>
</tbody>
</table>

**Turnover rates**

**Trust level**

From April 2018 to March 2019, the trust reported a turnover rate of 31.2% for medical staff in medicine. This was higher than the trust target of 8%. Turnover data for medical staff includes trainee grades which may have inflated the rate.

- Lincoln County Hospital medicine department: 26.4%
- Pilgrim Hospital medicine department: 36.4%

A breakdown of turnover rates by ward for each site is below.

**Lincoln County Hospital name**

Nine of the 11 medical wards had turnover recorded from April 2018 to March 2019. The five wards with the highest turnover are shown below:

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly care inpatients</td>
<td>50.3%</td>
</tr>
<tr>
<td>Respiratory medicine inpatients</td>
<td>39.9%</td>
</tr>
<tr>
<td>Cardiology inpatients</td>
<td>35.3%</td>
</tr>
<tr>
<td>Nephrology inpatients</td>
<td>31.7%</td>
</tr>
<tr>
<td>Clinical Oncology inpatients</td>
<td>20.3%</td>
</tr>
</tbody>
</table>

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

**Sickness rates**

**Trust level**

From April 2018 to March 2019, the trust reported a sickness rate of 1.7% for medical staff in medicine. This was lower than the trust target of 4.5%.

- Lincoln County Hospital medicine department: 2.2%
- Pilgrim Hospital medicine department: 1.3%

A breakdown of the five wards with the highest sickness rates at each site is shown below.

**Lincoln County Hospital name**

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical haematology inpatients</td>
<td>7.2%</td>
</tr>
<tr>
<td>Rehabilitation medicine inpatients</td>
<td>5.2%</td>
</tr>
<tr>
<td>Respiratory medicine inpatients</td>
<td>4.1%</td>
</tr>
<tr>
<td>Acute medicine</td>
<td>4.0%</td>
</tr>
<tr>
<td>Elderly care inpatients</td>
<td>1.9%</td>
</tr>
</tbody>
</table>
Bank and locum staff usage

Please note that the trust confirmed that they were unable to provide accurate establishment hours by department and location in all cases. Therefore, we have not calculated the proportion of hours filled by bank and locum staff or left unfilled as this may be misleading.

Managers could not always access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

Trust level

The table below shows the number of medical hours in medicine by site from April 2018 to February 2019 that were covered by bank and locum staff or left unfilled.

Over this time period, 34,994 hours were filled by bank staff and 151,453 hours were covered by locum staff to cover sickness, absence or vacancy for medical staff. The trust was unable to fill 15,843 of the available hours with either bank or locum staff.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank usage</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>3,347</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>13,132</td>
</tr>
<tr>
<td>Louth County Hospital</td>
<td>19</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>18,496</td>
</tr>
<tr>
<td>Total</td>
<td>34,994</td>
</tr>
</tbody>
</table>

Lincoln County Hospital

The table below shows the number of medical hours in medicine at Lincoln County Hospital from April 2018 to February 2019 that were covered by medical and locum staff or left unfilled.

Over this time period, 13,132 hours were filled by bank staff and 73,368 hours were covered by locum staff to cover sickness, absence or vacancy for qualified nurses. The trust was unable to fill 7,915 hours of the available hours with either bank or locum staff.

The five departments with the highest numbers of combined bank, locum and unfilled hours are shown.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank usage</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>8,327</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>2,433</td>
</tr>
<tr>
<td>General Medicine</td>
<td>0</td>
</tr>
<tr>
<td>Care of the Elderly</td>
<td>207</td>
</tr>
<tr>
<td>Stroke Medicine</td>
<td>0</td>
</tr>
<tr>
<td>Core service total</td>
<td>13,132</td>
</tr>
</tbody>
</table>

Staffing skill mix

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)
In January 2019, 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 the same.

**Staffing skill mix for the 200 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>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career</td>
<td>14%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>16%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>20%</td>
<td>20%</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 - Medical (01/01/2019 - 31/01/2019)

The medical staff did not always match the planned number on all shifts in each department. On Colton Coleby ward there were fewer junior staff than there should have been. At times medical staff were deployed elsewhere such as MEAU to help support those areas.

The service did not always have a consultant on call during evenings and weekends. Consultant cover at weekends was mostly through an on-call system. However, clinical staff on care of the elderly wards told us medical cover fluctuated and could be unpredictable.

The service did not always have a good skill mix of medical staff on each shift. The Consultant workforce within the stroke unit had been recognised by the trust as a fragile service. There was poor retention of staff and difficulty in recruiting into the posts. It was recognised by leaders that a review of the workforce model with skill mix changes was required.

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. During our inspection we reviewed a sample of 24 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. Risk assessments were repeated at regular intervals according to the patients’ clinical condition or the risks identified.

All sets of nursing notes were clearly documented, the care plans were easy to follow, reviewed and updated regularly. The trust used their own ‘essence of care’ templates for patient care planning which could be personalised around the patient’s individual needs.

Results reporting for imaging and pathology was available electronically these systems were password protected.
When patients transferred to a new team, there were minimal delays in staff accessing their records.

Allergies where required were documented on patient drug charts. However, these were not always signed and dated to confirm that they were accurate.

Medical and nursing records were kept as paper copies, the trust utilised an electronic system to record patient observations (NEWS2).

Records were not stored securely. We saw lockable trolleys on all wards that were not always used. We saw notes kept unsecured in the trolleys but with the lock open, notes were also seen on nurses’ stations unattended.

**Medicines**

**The service did not always use systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when prescribing and storing medicines. However, we saw that where patients had been assessed as suitable for self-administration, medicines were not checked to ensure they remained safe for use.

We saw problems with Self Administration of Medication (SAM) where medicines in use by patients were either not labelled or there was incorrect information on the label. In addition, we found a patient self-administering an eye drop that was beyond its expiry date. Although we saw few instances of medicines being omitted we found that, when patients had been transferred between wards medicines, including antibiotics and analgesics, had been missed.

Staff did not always complete the necessary documentation to demonstrate safe prescribing. We saw a diabetic patient with a low blood glucose reading receiving insulin who did not have their blood glucose checked appropriately following food being given.

Staff followed current national practice to check patients had the correct medicines on arrival in the hospital. Staff advised that lack of check of the discharge letters by pharmacy staff led to potential errors in medicines provision. In addition, patients transfer home or to alternative care settings was sometimes delayed due to difficulties obtaining medicines to take out.

Staff told us that To Take Out (TTO) medications may be delayed due to the timing of pharmacy staff visiting the wards and there was a limited service at weekends which meant that some adjustments to dispensing were not possible.

We observed fridge temperature checks on seven of the medical wards. Maximum and minimum temperatures were recorded daily. However, on Burton ward there was a couple of occasions in the past two months where the readings were recorded as being above the recommended maximum temperature we did not see any documented action taken to resolve this.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. We saw evidence of appropriate storage of medicines, however, we saw occasions where medicines with a short expiry date when opened were not annotated accordingly.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, whilst staff were aware of safety alerts and recalls we did not see an effective feedback mechanism such that the trust was assured appropriate actions had been taken.
Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. We did not observe any inappropriate prescribing.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. Information on the medicines administration charts demonstrated that antibiotics were reviewed in line with trust policy and patients told us they received information about their medicines.

We saw evidence of timely medicines reconciliation by pharmacy staff and saw this in action to prevent medication being missed.

We reviewed six drug charts of patients that were prescribed antibiotics. On all six drug charts we saw that there was an indication as to why the patient was taking them.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they were provided with feedback after reporting an incident and that learning from incidents was shared across areas through staff meetings.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Learning disability grab packs were created following staff being unable to support the needs of a patient with a learning disability, communication folders were also created and a E-learning strategy group had been created.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if or when things went wrong. All staff we spoke to during our inspection were aware of Duty of Candour and their role and responsibilities in relation to the Duty of Candour. Staff could give examples of when this would need to be applied.

Staff reported all incidents that they should report. The service had processes in place to prevent harm to patients. Staff understood their responsibilities to raise concerns, to record safety incidents and how to report them. The hospital used an electronic online system for reporting incidents. Most staff knew how to access the system and their responsibilities to report incidents and felt confident to do so. All staff could give examples of when they had or would report an incident.

The service inconsistently held mortality reviews as part of the Lincolnshire mortality collaborative. Outcomes and action points were identified during these meetings.

**Never Events**

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

From March 2018 to February 2019, the trust reported no never events in medicine.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 86 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from March 2018 to February 2019.

Breakdowns of the serious incidents by type and trust site are shown in the tables below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>48</td>
<td>55.8%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>20</td>
<td>23.3%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>8</td>
<td>9.3%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>4</td>
<td>4.7%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>4</td>
<td>4.7%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Trust-wide</strong></td>
<td><strong>86</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site name</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Boston Hospital</td>
<td>43</td>
<td>50.0%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>39</td>
<td>45.3%</td>
</tr>
<tr>
<td>Grantham District Hospital</td>
<td>4</td>
<td>4.7%</td>
</tr>
<tr>
<td><strong>Trust-wide</strong></td>
<td><strong>86</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Lincoln County Hospital

In accordance with the Serious Incident Framework 2015, Lincoln County Hospital reported 39 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from March 2018 to February 2019:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>20</td>
<td>51.3%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>10</td>
<td>25.6%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>4</td>
<td>10.3%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>2</td>
<td>5.1%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>2</td>
<td>5.1%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

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 35 new pressure ulcers, 14 falls with harm and eight new urinary tract infections in patients with a catheter from March 2018 to March 2019 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter UTIs at United Lincolnshire Hospitals NHS Trust**

![Graph showing prevalence rate](image)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

*(Source: NHS Digital - Safety Thermometer)*

Safety thermometer data was displayed on wards for staff and patients to see. Staff used the safety thermometer data to further improve services. Each ward used a safety and quality noticeboard to indicate their track record of how many days it had been since the ward had a hospital acquired pressure ulcer or fall. Where these had developed or happened on the ward the actions taken were displayed.

**Is the service effective?**

**Evidence-based care and treatment**
The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients’ subject to the Mental Health Act 1983.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Patient’s physical, mental health and social needs were holistically assessed, and their care, treatment and support were delivered in line with legislation, standards and evidence-based guidance. This included the National Institute for Health and Care Excellence (NICE). A sepsis lead practitioner worked with staff across all wards, following identifying a patient had red flag sepsis a sepsis 6 care bundle was completed.

All sets of nursing notes were clearly documented, the care plans were easy to follow, reviewed and updated regularly. The trust used their own ‘essence of care’ templates for patient care planning which could be personalised around the patient's individual needs.

Senior staff told us that the use and awareness of the mental health act was rare and they were trying to raise awareness and educate staff. They told us that from July 2019 training around the mental health act would be mandatory.

The specialist nurse from the frailty assessment unit assessed and took patients directly from MEAU and ambulatory care, if their length of stay was likely to be less than 72 hours.

We saw evidence in care plans where the patient’s psychological and emotional needs were considered and assessed. We saw a patient with a learning disability on one ward had a teddy bear that was used as a comforter to help calm the patient, staff told us they were made aware of this as it was discussed during handovers.

The endoscopy suite had recently regained its Joint Advisory Group (JAG). This meant care, treatment and procedures 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 protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Trust policies were in place to ensure staff did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age. Staff we spoke with knew how to access policies relevant to their specialty area.

Patients’ clinical conditions and outcomes were assessed using nationally recognised assessment tools and audits. For example, the National Early Warning Scores (NEWS) 2 for monitoring clinical observations, the falls risk assessment tool and the universal malnutrition-screening tool (MUST).

The trust had introduced quality and safety audits. These ensured assessments and actions relating to falls, tissue viability, fluid management, nutrition medications and catheter care were completed appropriately and used as an indicated as to where improvements needed to be made.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

At our previous inspection we raised some about the use conscious sedation for patients who underwent procedures in the cardiac catheter lab, verbal contact should be maintained during conscious sedation. At the time of this inspection we were unable to be present during the procedure so could not witness if changes had been implemented. We were told that staff had not received any further training since our last inspection as a new conscious sedation policy had been drafted but not approved. Once approved the department had planned to re-train, we requested a copy of the new draft sedation policy, but we did not receive this. Staff told us that
there had been an increased awareness for nursing and medical staff to monitor the patient throughout the procedure.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Staff made sure patients had enough to eat and drink. We observed a meal time on the stroke unit all food was prepared in the hospitals main kitchen and distributed to the wards. The ward staff were responsible for serving and taking meals to the patients there was adaptive equipment including plates, cups and cutlery for those that needed it. We saw staff assisting patients to eat their meals.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. There was evidence of nutritional care plans which were regularly reviewed and updated. This included completed and up to date malnutrition universal scoring tools (MUSTs) and waterlow scores.

Referrals were made to dietitians where concerns were identified about the amount patients were eating or their weight. We saw dietitian entries in patient medical records outlining plans for nutrition and advise to medical and nursing staff.

On Ashby ward we saw a meals chart displayed in the kitchen. This showed staff the meal requirements for each patient and any special diet requirements that they had.

Patients had jugs of water within reach on their bedside tables. We observed these were mostly filled.

Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it. We reviewed four sets of patient nursing notes on the stroke unit. Two of which required a Speech and Language Therapist (SALT) review, both patients swallowing assessments were carried out within six hours of admission.

Staff did not always fully and accurately completed patients’ fluid and nutrition charts where needed. We saw completion of fluid balance charts were variable across all wards. Fluid balance charts did not always have an accurate input or output with ‘wet pad’ being documented without a numerical value of the output.

Staff told us that fruit was not readily available as this was an infection and control risk. They also told us that yoghurts are not allowed to be stocked in the ward fridges. However, these were often needed for swallowing assessments as well as patients requesting them for snacks or at breakfast time. Staff were unable to say what the rationale behind these decisions were.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Patients received pain relief soon after requesting it. Staff used an as-needed (PRN) medicine protocol to ensure patients had regular pain relief and we saw this was documented on patient drug charts.

Staff prescribed, administered and recorded all pain relief accurately.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw that there were non-verbal ways where patients could alert staff
if they were in pain. On Navenby ward they would use alternatives to verbally telling staff that they were in pain. This included picture card with smiling and sad faces on to assess pain. This was particularly helpful for patients with learning disabilities and patients that were unable to communicate.

There was a referral service in place for patient to be referred to a pain management consultant. It was the responsibility of individual ward medical teams to assess ongoing problems and to prescribe analgesia.

There was an adult pain team (APT). This met the Faculty of Pain Medicine’s Core Standards for Pain Management (2015). The recommendation is that all hospitals should provide an APS staffed by appropriately trained consultants and nurses. Consultants should have completed higher pain training (ideally advanced pain training for lead clinicians). Senior APS nursing staff should be nurse prescribers.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements but did not always achieve good outcomes for patients.**

Leaders recognised that improvements needed to be made with initial diagnostic pathways for lung cancer patients. From April 2019 the service had introduced the ‘Manchester lung’ cancer diagnostic pathway on a three month trial period. General Practitioners (GPs) referred patients with cancer concerns for a chest X-ray with immediate reporting. This allowed for direct booking to CT and appropriate test and treatment bundles being identified before patients attended their first outpatient appointment. Manchester’s Lung pathway aimed to help improve early diagnosis and survival rates for lung cancer by providing quick, easily accessible screenings for those deemed at higher risk of lung conditions.

The service participated all relevant national clinical audits. The service did not always perform well in national clinical outcome audits and managers use the results to improve services further.

Information about the outcomes of patient’s care and treatment, both physical and mental where appropriate, were routinely collected and monitored. This was done through local audits and national audits. Local audits included but not limited to, appropriate completion of NEWS2, fluid balance chart and visual infusion phlebitis (VIP) scores. VIP is a scoring system used to identify early signs of phlebitis, along with prompt removal of peripheral intravenous cannulas. Managers shared and made sure staff understood information from the audits.

Managers carried out a comprehensive audit programme and used information from the audits to improve care and treatment. One ward manager had noticed that there was poor admission documentation and provided checks and gave feedback to nursing staff to make improvements.

Improvement is checked and monitored. There was a patient and carer experience strategy which we reviewed. The strategy set out how the use of patient feedback could be used to help improve the patient journey.

**Relative risk of readmission**

**Trust level**

From December 2017 to November 2018, patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

Of the top three specialties by number of admissions:

- Patients in clinical oncology had a similar to expected risk of readmission for elective
admissions to the England average

- Patients in medical oncology and clinical haematology had lower than expected risks of readmission for elective admissions

Elective Admissions – Trust Level

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

From December 2017 to November 2018, patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Patients in general medicine, cardiology and clinical oncology had lower than expected risks of readmission for non-elective admissions.

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 represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (01/12/2017 - 30/11/2018))

Lincoln County Hospital

From December 2017 to November 2018, patients at Lincoln County Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

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

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
From December 2017 to November 2018, patients at Lincoln County Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

All of the top three specialties by number of admissions had lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.

### 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 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (01/12/2017 - 30/11/2018))

### Sentinel Stroke National Audit Programme (SSNAP)

**Lincoln County Hospital**

Lincoln County Hospital takes part in the Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade C in the latest audit, covering the period from October to December 2018. Over the last four audits the trust achieved grade C four times, with an improvement to grade B from April to June 2018.

#### Team centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Dec 17 - Mar 18</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>C</td>
<td>D↓</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>E</td>
<td>C↑↑</td>
<td>D↓</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>C↓</td>
<td>C</td>
<td>D↓</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>D↓</td>
<td>C↑</td>
<td>D↓</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
</tr>
<tr>
<td>Team-centred total key indicator level</td>
<td>C↓</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
</tr>
</tbody>
</table>

#### Overall Scores

<table>
<thead>
<tr>
<th></th>
<th>Dec 17 - Mar 18</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>C↓</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
<td>A↑</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>C↓</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
</tr>
</tbody>
</table>
The national standard is that patients who experience a stroke spend at least 90% of their inpatient stay in a specialist stroke unit. The data the trust provided between December 2018 and February 2019 showed that the trust achieved 80%.

Since our last inspection the hospitals SSNAP score had decreased from an overall score of a B to a C. Staff told us that referral times to the specialist stroke practitioners from the emergency department can be delayed as there is a need to identify stroke patients faster.

**Lung Cancer Audit**

The table below summarises the trust’s performance in the 2017 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td>6.4%</td>
<td>Does not meet the audit aspirational standard</td>
<td>✗</td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate (Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>36.1%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>16.5%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment (For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>49.8%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>57.7%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
</tbody>
</table>

(Source: National Lung Cancer Audit)

Audit results guide

**National Audit of Inpatient Falls**

**Lincoln County Hospital**
The table below summarises Lincoln County Hospital's performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>Yes</td>
<td>n/a</td>
<td>✓</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) (Having a vision assessment is indicative of good practice in falls prevention)</td>
<td>100.0%</td>
<td>Green</td>
<td>✓</td>
</tr>
<tr>
<td>Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) (Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)</td>
<td>20.0%</td>
<td>Red</td>
<td>❌</td>
</tr>
<tr>
<td>Crude proportion of patients assessed for the presence or absence of delirium (if applicable) (Having an assessment for delirium is indicative of good practice in falls prevention)</td>
<td>46.7%</td>
<td>Red</td>
<td>❌</td>
</tr>
<tr>
<td>Crude proportion of patients with a call bell in reach (if applicable) (Having a call bell in reach is an important environmental factor that may impact on the risk of falls)</td>
<td>84.6%</td>
<td>Green</td>
<td>❌</td>
</tr>
</tbody>
</table>

Chronic Obstructive Pulmonary Disease Audit

Lincoln County Hospital

The table below summarises Lincoln County Hospital’s performance in the 2018 Chronic Obstructive Pulmonary Disease Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen by a member of the respiratory team within 24hrs of admission? (Specialist input improves processes and outcomes for COPD patients)</td>
<td>59.1%</td>
<td>Worse than the national aggregate</td>
<td>❌</td>
</tr>
<tr>
<td>Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) (Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for</td>
<td>95.0%</td>
<td>Worse than the national aggregate</td>
<td>❌</td>
</tr>
</tbody>
</table>
### Assisted Ventilation, and Death

<table>
<thead>
<tr>
<th>Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival (NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</th>
<th>Not available</th>
<th>n/a</th>
<th>n/a</th>
</tr>
</thead>
</table>

### Non-invasive Ventilation within 3 Hours of Arrival

<table>
<thead>
<tr>
<th>Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy (Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</th>
<th>32.8%</th>
<th>Better than the national aggregate</th>
<th>☒</th>
</tr>
</thead>
</table>

### Patients for Whom a British Thoracic Society, or Equivalent, Discharge Bundle Was Completed for the Admission

<table>
<thead>
<tr>
<th>Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (Completion of a discharge bundle improves readmission rates and integration of care)</th>
<th>75.1%</th>
<th>Better than the national aggregate</th>
<th>✓</th>
</tr>
</thead>
</table>

### Patients with Spirometry Confirming FEV1/FVC Ratio <0.7 Recorded in Case File

<table>
<thead>
<tr>
<th>Percentage of patients with spirometry confirming FEV1/FVC ratio &lt;0.7 recorded in case file (A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt)</th>
<th>38.3%</th>
<th>Better than the national aggregate</th>
<th>☒</th>
</tr>
</thead>
</table>

### National Audit of Dementia

**Lincoln County Hospital**

The table below summarises Lincoln County Hospital’s performance in the 2017 National Audit of Dementia.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good (A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</td>
<td>83.3%</td>
<td>Top 25% of hospitals</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of staff responding “always” or “most of the time” to the question “Is your ward/ service able to respond to the needs of people with dementia as they arise?” (This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</td>
<td>84.6%</td>
<td>Top 25% of hospitals</td>
<td>No current standard</td>
</tr>
<tr>
<td>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that</td>
<td>27.9%</td>
<td>Middle 50% of hospitals</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
may indicate the presence of delirium
(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)

Multi-disciplinary team involvement in discussion of discharge
(Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)

|        | 78.7% | Middle 50% of hospitals | No current standard |

## Competent staff

The service made sure most staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. Processes were in place to induct new staff and ensure they were competent to fulfil their roles. Staff told us they received a comprehensive induction that included both a trust wide and local induction. The local induction included orientation to the area and support to complete local competencies.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. A newly appointed health care assistant (HCA) told us that she was getting additional training which included how to complete documentation appropriately for example, food and fluid balance charts. They also had the opportunity to complete the care certificate. The care certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of those working in the health and social care sectors.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend.

Managers made sure staff received any specialist training for their role. Specialist wards had competencies requiring sign off before providing specialist treatment. For example, nurses on Colton-Coleby, completed respiratory training including Non-invasive Ventilation (NIV) training.

Staff on Ingham and Waddington ward had either completed or were in the process of completing national chemotherapy competencies following them being updated.

Managers told us that they monitored and identified poor staff performance promptly and supported staff to improve. This included clinical supervision and identifying any learning needs.

Volunteers were recruited across medical wards and were trained and supported for the roles they undertook. Managers recruited, trained and supported volunteers to support patients in the service.

Staff told us that there were link roles on the wards where they received training from lead nurses such as infection prevention and control and tissue viability.
Most medical staff we spoke with said they received a good level of support from their consultants who were approachable. There is ward and patient case, based education. There were also weekly teaching sessions throughout the week dependent on the department. On one ward junior staff told us that they ward rounds offer teaching by role reversal where the consultants made notes and the juniors suggested the treatment decisions.

Most staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff on the discharge lounge told us that they had not received an appraisal in two years.

Junior staff on MEAU told us about concerns that they had around their education. This was mostly due to many consultants being locums and lacked the responsibility to assess trainees and observe practical procedures that were required for their portfolios.

**Appraisal rates**

**Trust level**

From April 2018 to February 2019, 75.9% of staff within medicine department at the trust received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>110</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>24</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>90</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>449</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>8</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>336</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>5</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>0</td>
</tr>
</tbody>
</table>

**Lincoln County Hospital**

From April 2018 to February 2019, 76.9% of staff within medicine department at Lincoln County Hospital received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>59</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>13</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>64</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>259</td>
</tr>
</tbody>
</table>

United Lincolnshire Hospitals NHS Trust Post-inspection Evidence appendix
Support to doctors and nursing staff | 162 | 258 | 62.8% | 95% | No
Qualified healthcare scientists | 5 | 17 | 29.4% | 95% | No
Other qualified scientific, therapeutic & technical staff | 0 | 2 | 0.0% | 95% | No

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Patients had their care pathways reviewed by the relevant consultants. All 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.

There were full team daily handovers, with ward nursing staff and medical staff. Multidisciplinary ward rounds were also carried out daily. Staff reported that they worked well with all the multidisciplinary team.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Relevant professionals were involved in the assessment, planning and delivery of patient care. We observed good working relationships between a range of health professionals, such as occupational therapists and physiotherapists within the trust.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was a discharge co-ordinator based on the wards. They would assist ward staff and other teams of health professionals to plan the discharges of patients who have complex needs including continuing health care, end of life, complex district nursing and the management of long-term conditions.

**Seven-day services**

Not all key services were available seven days a week to support timely patient care.

Staff could not always call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Consultants led daily ward rounds on all wards, this did not always include weekends. Patients are reviewed by consultants depending on the care pathway. Consultant cover was provided seven days a week, in some areas this was through an on-call system out of hours and at weekends.

Patients on MEAU were not always seen twice a day, there was also problems with getting specialist reviews for patients. Not all specialist consultants proactively rang or visited the unit to see if there were any patient referrals that required them to be seen. Staff told us that if specialist referrals are not made before 10am patients were often not seen until the next day.

Due to staff shortages there was no seven day service for SALT, meaning that there were waits for up to 72 hours to assess patients with complex swallowing needs. However, all nurses on the stroke unit were trained to perform basic swallowing assessments. At the time of our inspection there was plans to recruit more staff so there was potential to increase the service. One SALT nurse was currently going through their training and competencies to become a dysphagia trained practitioner. A dysphagia practitioner is someone who has the competency to assess the needs of patients with feeding and swallowing difficulties.
The Endoscopy suite had extended services and provided procedures on Saturdays on Sundays. There were plans to increase the evening clinics. However, managers recognised that there would need to be an increase in staff and equipment to be able to do this.

Physiotherapy staff worked across the service Monday to Friday and were ward based. The stroke ward had therapy services at the weekend. Patients on the stroke unit told us that they received daily physiotherapy and occupational therapy input. For one patient we saw that they had been given daily sessions to help aid their reablement.

The safeguarding team were available Monday to Friday and staff were able to refer patients to them. Outside of this time an on call service was available.

Diagnostic imaging and pharmacy services were available on a 24-hour basis, with emergency on-call cover overnight.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

Staff in the Endoscopy suite were educating and engaging with the local community by attending a local show within the city to promote breast and bowel cancer screening.

Health promotion information from national stroke organisations was readily available on the stroke ward.

Each patient has risk assessments completed on admission this included skin assessments, risk of malnutrition and falls risk assessment. We saw the use of care plans across all wards and these were mostly completed well.

The service had relevant information promoting healthy lifestyles and support on every ward. Display boards across medical wards provided awareness and information about pressure area care, diabetic care and information about learning disabilities.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw nursing assessments which considered patient health promotion such as drug and alcohol abuse.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. The service had policies in place regarding consent and the Mental Capacity Act 2005 (MCA). Staff could access these through the intranet. The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

Staff made sure patients consented to treatment based on all the information available.
Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw staff gaining verbal consent from patients to assist with their personal care needs.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff we spoke to were aware of the requirement to complete a mental capacity assessment and to act in the patients’ best interests when they were unable to make a specific decision for themselves. We found that mental capacity assessments had been undertaken for other patients who were unable to make their own decisions and decisions were taken in their best interests.

We saw chemical restraint risk assessments in patients notes, these were reviewed by Matrons and an action plan created if any problems were identified. Chemical sedation 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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw evidence of mental capacity assessments and best interest decisions, in relation to “do not attempt cardio-pulmonary resuscitation” (DNACPR) orders, when patients could not be involved in the decision-making process. We saw that discussions with family and carers was documented.

Senior staff told us they worked closely with the local mental health provider to support the management of patients detained under the Mental Health Act. The trust had good joint working relationships with the local mental health trust and there was a service level agreement in place.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. They recognised that there was limited awareness of the Mental Health Act. The trust was raising awareness by implementing mandatory training which was due to launch in July 2019.

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

Staff implemented DoL safeguards in line with approved documentation.

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The MCA training delivered covers all levels required and DoLS training is included in the same session so is not reported separately.

Compliance for the MCA/DoLS training course as of February 2019 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>548</td>
</tr>
</tbody>
</table>

In medicine the target was not met for the MCA/DoLS training module for which qualified nursing staff were eligible, although the completion rate was above 88%.
Compliance for the MCA/DoLS training course as of February 2019 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>95</td>
<td>108</td>
<td>88.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the target was not met for the MCA/DoLS training module for which medical staff were eligible, although the completion rate was above 85%.

Lincoln County Hospital

Compliance for the MCA/DoLS training course as of February 2019 at Lincoln County Hospital for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>296</td>
<td>334</td>
<td>88.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the target was not met for the MCA/DoLS training module for which qualified nursing staff were eligible, although the completion rate was above 88%.

Compliance for the MCA/DoLS training course as of February 2019 at Lincoln County Hospital for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>56</td>
<td>62</td>
<td>90.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In medicine the target was met for the MCA/DoLS training module for which medical staff were eligible.

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

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patients that we spoke to mostly spoke positively about the care they received and staff responded to their needs promptly. However, some staff told us that when there was staff shortages they felt that care was compromised and could not respond to patients as quickly as they would have liked.

Friends and Family test performance

Trust level

The Friends and Family Test response rate for medicine at the trust was 27% which was better than the England average of 24% from March 2018 to February 2019.
Please note that the response rates for some wards/units were low, for example wards 7B and 8A and Dixon Ward had response rates of 17%. Care should be taken when interpreting the recommendation rates for these wards and units as the small sample size will impact on the ability to generalise the results. In addition, Ward 6B had a response rate of over 100% suggesting issues with the data quality.

A breakdown of FFT performance by ward for medical wards at trust level over the same time period is shown below. All the wards and departments had annual recommendation rates of 80% and above with the exceptions of Wards 8A and 7B which had an annual recommendation rate of 73% and 79%, respectively.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp1,2</th>
<th>Resp. Rate</th>
<th>Percentage recommended2</th>
<th>Annual perf1</th>
</tr>
</thead>
<tbody>
<tr>
<td>6B</td>
<td>329</td>
<td>103%</td>
<td>100% 100% 100% 98% 100% 100% 95% 97% 100% 98%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 6</td>
<td>285</td>
<td>57%</td>
<td>100% 100% 100% 96% 93% 100% 100% 95% 100% 94% 100% 93%</td>
<td>93%</td>
</tr>
<tr>
<td>Ward 1</td>
<td>277</td>
<td>30%</td>
<td>100% 100% 100% 100% 100% 94% 100% 100% 100% 100%</td>
<td>98% 93% 98%</td>
</tr>
<tr>
<td>Burton</td>
<td>267</td>
<td>39%</td>
<td>100% 100% 100% 94% 100% 100% 100% 100% 100% 100%</td>
<td>100% 100% 93%</td>
</tr>
<tr>
<td>6A</td>
<td>261</td>
<td>64%</td>
<td>100% 97% 100% 100% 100% 100% 100% 100% 100% 100%</td>
<td>94% 96% 98%</td>
</tr>
<tr>
<td>CSSU</td>
<td>251</td>
<td>26%</td>
<td>100% 91% 100% 95% 96% 85% 90% 92% 93% 100% 100%</td>
<td>95%</td>
</tr>
<tr>
<td>Johnson</td>
<td>229</td>
<td>26%</td>
<td>83% 92% 89% 100% 79% 91% 87% 95% 94% 91% 94% 91%</td>
<td>94%</td>
</tr>
<tr>
<td>Carlton Coleby</td>
<td>214</td>
<td>21%</td>
<td>93% 75% 86% 89% 88% 94% 100% 80% 79% 79% 78% 88%</td>
<td>85%</td>
</tr>
<tr>
<td>Waddington</td>
<td>198</td>
<td>19%</td>
<td>86% 94% 94% 94% 95% 92% 86% 90% 100% 88% 100% 87% 89%</td>
<td>91%</td>
</tr>
<tr>
<td>Frailty Assessment Unit</td>
<td>166</td>
<td>27%</td>
<td>100% 100% 100% 100% 100% 100% 100% 100% 100% 100%</td>
<td>89%</td>
</tr>
<tr>
<td>7A</td>
<td>155</td>
<td>20%</td>
<td>88% 85% 91% 100% 100% 100% 100% 91% 93% 88% 86% 82% 90%</td>
<td>90%</td>
</tr>
<tr>
<td>Dixon</td>
<td>131</td>
<td>17%</td>
<td>100% 70% 69% 89% 82% 92% 75% 100% 82% 81% 80% 90% 83%</td>
<td>83%</td>
</tr>
<tr>
<td>Lancaster</td>
<td>131</td>
<td>63%</td>
<td>100% 100% 100% 100% 95% 100% 100% 100% 100% 100% 100% 99%</td>
<td>99%</td>
</tr>
<tr>
<td>7B</td>
<td>130</td>
<td>17%</td>
<td>87% 86% 91% 83% 83% 75% 86% 90% 92% 77% 100% 89% 79%</td>
<td>79%</td>
</tr>
<tr>
<td>8A</td>
<td>127</td>
<td>17%</td>
<td>60% 73% 83% 83% 83% 83% 82% 78% 82% 80% 70% 73%</td>
<td>73%</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>125</td>
<td>32%</td>
<td>100% 90% 80% 93% 88% 93% 74% 88% 88% 88% 88% 88%</td>
<td>88%</td>
</tr>
</tbody>
</table>

**Key**
- **100%** indicates highest score
- **50%** indicates middle score
- **0%** indicates lowest score

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

**Lincoln County Hospital**

The Friends and Family Test response rate for medicine at Lincoln County Hospital was 24% which was the same as the England average from March 2018 to February 2019.

Please note that the response rates for some wards/units were low, for example Dixon Ward had a response rate of 17%. Care should be taken when interpreting the recommendation rates for these wards and units as the small sample size will impact on the ability to generalise the results. A breakdown of FFT performance by ward for medical wards at Lincoln County Hospital over the same period is shown below. Dixon Ward had the lowest overall annual recommendation rate, at 83%, followed by Carlton Coleby Ward with 85%.
1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

We observed staff to be caring and compassionate with patients and their relatives. We observed positive and supportive interactions between patients and staff. Patients told us that the staff treated them with kindness.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff followed policy to keep patient care and treatment confidential. Staff promoted privacy, and patients were treated with dignity and respect. We saw that curtains around bed spaces within the bays were closed and single room doors were closed during patient care to protect the privacy and dignity of patients.

Patients said staff treated them well and with kindness. We observed feedback from relatives and patients displayed on boards across some wards. This included comments such as “staff are always friendly and caring.”

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. On one ward staff told us they hold a monthly breakfast club, staff take patients that are well enough to the canteen for coffee and conversation.

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Clinical nurse specialists were available for advice and support in several specialties including respiratory services and cancer services. Staff could refer patients for additional support if necessary.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Patients who were confused were offered reassurance. A cohort bay system was used to provide constant nurse care to patients who were confused. We observed positive interactions from staff in cohort bays. Twiddle mitts were available for patients as a distraction and comforter.
Patients’ spiritual needs were considered irrespective of any religious affiliation or belief. The chaplaincy service supported spiritual care for patients and relatives.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The service had a ‘snowdrop room’ where families could spend time to collect their thoughts, speak with the chaplains or get advice and support from healthcare staff.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Relatives spoke positively about the care their relatives and received and that they were kept informed about the patients care and treatment.

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

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

We saw patients and relatives were greeted with friendly responses when they asked for assistance or information. On two occasion we observed relatives had requested to speak to nursing staff. Nursing staff were prompt with responding to the request and had the conversation at the patient's bedside.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients felt that staff communicated with them in a way which they could understand their care, treatment and condition. One patient and their family commented, “all staff have been marvellous and without fault throughout, we have been kept informed and reassured and given tea and coffee.”

Staff supported patients to make advanced decisions about their care. We saw the use of best interest forms for patients who lack capacity. As part of this the need for an independent mental capacity advocate (IMCA) was assessed. An IMCA is an advocate who has been specially trained to support people who are not able to make certain decisions for themselves and do not have family or friends who are able to speak for them.

Staff told us that when discharging patients with additional communication needs they would discuss with family and explain medications, this would also be outlined on the discharge letter. Staff would also use translation services to ensure information was understood by the patient.

Staff made sure patients and those close to them understood their care and treatment.

We attended an MDT meeting for medicine which was held weekly to discuss patients with complex needs. We saw effective MDT working. Consultants, junior doctors, ward managers, ward staff, included physiotherapists, occupational therapists, dieticians, speech and language therapists (SALT). During these meetings patients with complex needs and complex discharges were discussed. There were separate meetings that were held for key workers to attend and family to attend.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
Managers planned and organised services so they met the changing needs of the local population. The service worked collaboratively with local social services to facilitate timely and appropriate discharges for those patients requiring complex social care packages in the community. When there were delays in assessment from care and nursing homes the trust utilised discharge trusted assessors designed to reduce delays when patients were ready for discharge from hospital.

The service relieved pressure on other departments when they could treat patients in a day. The frailty assessment team aimed to improve care and reduce the length of stay and readmission rates for elderly patients with complex medical needs. Frailty assessments were completed for patients referred and we saw evidence of the frailty team having regular contact with patients to support their care and discharge needs.

Each ward had established visiting times for relatives and friends. However, staff worked flexibly within these times to facilitate the needs of each patient.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

The service had systems to help care for patients in need of additional support or specialist intervention. Ashby ward had recently appointed a rehabilitation specialist nurse, they also had the use of a therapy kitchen which was utilised by the therapy team as part of the patients reablement. This was used to assess a patient’s ability to prepare drinks and meals as they would at home taking in to account the patient’s ability to plan and organise the task.

Waddington ward, which provided haematology-oncology services, had a lead-lined side room for patients whose treatment resulted in a radioactive state.

Mental health liaison practitioners were available seven days a week. Outside of their operating hours a crisis response team was available.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. All staff had access to an interpreting service and to telephone language support. Some wards explained that patients or visitors could request certain printed information in a range of languages. On Ashby ward staff had used the translation service and booked a translator for an hour a day to be used with occupational/physiotherapy and for communication with other members of the MDT for one patient where English was not their first language. Staff had developed a basic communication system such as getting the patient to blink when asking closed questions and were using the Abbey pain scale. Some staff had attempted to learn the patients first language for simple communication needs. The Abbey Pain Scale is a standardised pain assessment tool developed for use in nonverbal patients or those patient’s who may be living with dementia.

The service had information leaflets available in languages spoken by the patients and local community.

Staff planned for patients living with mental health problems, learning disabilities and dementia to receive the necessary care to meet all their needs. This included through the enhanced care programme, which provided one-to-one support for patients with more complex needs.
The service had a dementia practitioner who would assess patients admitted to hospital with suspected dementia, to ensure that patients with dementia were getting the care that they needed through the hospitals’ mental health liaison teams. They also visited patients on the wards who had been identified with dementia and assessed what support they required. They involved families and carers to be able to provide support for the patient.

Discharge coordinators and allied healthcare providers worked alongside community partners to implement therapy plans on discharge. This aimed to help reduce the risk of readmission.

We saw medical outliers reviewed on two wards, staff reported that on average there could be between five to ten medical patients on the ward, this would be closer to ten during winter pressures.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. “All about me” cards were used for patients with learning disabilities, autism and dementia. These were beneficial to the patients’ experience and included details of patients’ likes and dislikes, which could be used to inform care when patients were unable to communicate their needs. We also saw hospital passports being used, we did however find that on one occasion this was in the back of the patients’ medical file where potentially it was not always seen by staff.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Snacks and drinks were available for patients to have at any time. This included biscuits, toast, cold drink and a variety of hot drinks such as tea and coffee. Specialist meals were available, for example halal, vegan and vegetarian. Different consistency of foods for patients requiring a soft or puree diet were also available.

The service had an effective communication aid books on some wards to help staff make sure people who have difficulties understanding or communicating get equal service in hospital. It provided advice and guidance to staff as well as non-verbal score cards and pictures containing key needs. Although these were available staff were not always aware of them. Patients’ communication needs were assessed on admission.

Staff on SEAU told us that medical patients could slow the flow of surgical patients. Consultants reviewed medical outliers mostly in the afternoon once they have completed ward rounds in their own areas. Ward staff would remind them if they haven’t been reviewed, at time this can be late in the day and staff have struggled to organise discharges. In some cases, this had caused patients to have to stay an additional night to ensure everything was in place for discharge.

Staff told us that there was no consultant review for medical patients on surgical wards at the weekends. Routine care was provided by SEAU based doctors.

We saw boards with patients’ name above their bed. There was space to add symbols to highlight and share information such as being able to identify that a patient had a learning disability. We saw this used on some wards but was inconsistently used across the service.

Not all wards were designed to meet the needs of patients living with dementia. Day rooms were rarely used for activities or socialising, we found on some wards that they were used as additional space to store equipment.

**Access and flow**

_**People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.**_

Managers and staff worked to make sure that they started discharge planning as early as
possible. Discharge coordinator were available on wards to and supported the clinical team in preparing plans for patients with complex needs. Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs.

The service had a discharge lounge that was open Monday – Sunday. The discharge lounge had 2 beds and 10 chairs where patients could be nursed. The unit had substantive staff but relied upon bank and agency staff to fill staffing gaps. There was a set criteria to ensure that patients were able to get the care they needed with the staff available there was no hoist so were unable to accept patients requiring to be hoisted. There were no isolation facilities to care for infected patients.

During our inspection the discharge lounge was used for patients awaiting TTO medications, hospital ambulance transport and their own transport. Staff on the discharge lounge told us that delays in hospital transport caused them to stay later to ensure all patients were discharged safely.

Wards had a daily nursing huddle, when they also talked about high risk patients, nutritional needs, discharges, and treatment escalation plans.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service had a medical emergency assessment unit (MEAU), this was a short stay ward designed for patients who were transferred from the emergency department. This helped to divert patients from the emergency department to provide a streamlined service. Most medical patients were admitted through MEAU, with a large portion transferred from the urgent and emergency care department following an initial assessment. Patients were usually admitted for further investigations or awaiting results to determine if a hospital admission was necessary. Patients were either discharged or admitted to a ward.

The service also provided emergency procedures to those patients suffering an acute heart attack 24/7, 365 days a year. This was provided at two dedicated cardiac catheter laboratories located onsite.

The service had systems in place to improve access to timely treatment. For example, there was an ambulatory care unit that provided a rapid access clinic to avoid unnecessary admissions for patients who could be treated as outpatients and managed there. This helped reduce the number of patients going to the emergency department and receiving timely treatment. However, at times this was used as an escalation unit and would have bedded patients which had an impact on patient flow.

Medical staff told us that a limited amount of specialist consultants would routinely visit MEAU to assist with the transfer process of admitting to the ward most appropriate for the patient or arranging discharge following specialist review. This had slowed down the discharge process and in same cases patients were in hospital longer than they needed to be.

There was an out of hours discharge policy that not all staff were aware of when asked about it.

Staff told us the main cause of discharge delays concerned patients waiting for social care placements or packages of care. Furthermore, delays in transport and delays with the preparation of medications to take away requested from pharmacy were a common cause.

**Average length of stay**

**Trust Level**

From January 2018 to December 2018 the average length of stay for medical elective patients at the trust was 5.5 days, which was lower than the England average of 6.0 days.
Of the top three specialties by number of admissions, average lengths of stay for elective patients in clinical oncology, gastroenterology and clinical haematology were lower than the England averages.

**Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>5.5</td>
<td>6.0</td>
</tr>
<tr>
<td>Clinical oncology</td>
<td>2.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>2.8</td>
<td>4.5</td>
</tr>
<tr>
<td>Clinical haematology</td>
<td>8.8</td>
<td>10.7</td>
</tr>
</tbody>
</table>

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

For medical non-elective patients, the average length of stay was 6.4 days, which was similar to the England average of 6.2 days.

Of the top three specialties by number of admissions, average length of stay for non-elective patients in:
- General medicine was higher than the England average.
- Cardiology was similar to the England average.
- Clinical oncology was lower than the England average.

**Non-Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>6.4</td>
<td>6.2</td>
</tr>
<tr>
<td>General medicine</td>
<td>6.4</td>
<td>5.7</td>
</tr>
<tr>
<td>Cardiology</td>
<td>5.1</td>
<td>5.3</td>
</tr>
<tr>
<td>Clinical oncology</td>
<td>3.4</td>
<td>5.3</td>
</tr>
</tbody>
</table>

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

**Lincoln County Hospital**

From January 2018 to December 2018 the average length of stay for medical elective patients at Lincoln County Hospital was 5.8 days, which was similar to England average of 6.0 days.

For the top three specialties by number of admissions, average lengths of stay for elective patients in clinical oncology, cardiology and clinical haematology were lower than the England averages.

**Elective Average Length of Stay - Lincoln County Hospital**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical oncology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical haematology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For medical non-elective patients, the average length of stay was 6.6 days, which was higher than England average of 6.2 days.

For the top three specialties by number of admissions, average length of stay for non-elective patients in:

- General medicine was higher than the England average.
- Cardiology and clinical oncology were lower than the England averages.

**Non-Elective Average Length of Stay - Lincoln County Hospital**

(Source: Hospital Episode Statistics)

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

From March 2018 to February 2019 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was consistently lower than the England average.

In the most recent month, February 2019, the trust performance was 76.8% compared to the England average of 87.2%.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**
From March 2018 to February 2019, two specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>90.3%</td>
<td>81.6%</td>
</tr>
</tbody>
</table>

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>Gastroenterology</td>
<td>65.4%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>58.7%</td>
<td>81.3%</td>
</tr>
<tr>
<td>General medicine</td>
<td>50.0%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Neurology</td>
<td>50.0%</td>
<td>90.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Patient moving wards per admission

The trust reported that they do not collect data on ward moves for non-clinical reasons.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

Trust-wide

From March 2018 to February 2019, there were 5,731 patient moving wards at night within medicine trust-wide.

Staff we spoke to told us that they raised concerns about patients who were moved at night and the appropriateness of the patients that were moved. Patients with confusion were often moved at night at staff felt that this was not in the patients best interest and had a negative impact on the patient’s mental wellbeing. Staff told us that they would complete an incident form when this happened.

Lincoln County Hospital

From March 2018 to February 2019, there were 4,432 patient moving wards at night within medicine at Lincoln County Hospital. The three wards/units with the highest numbers of moves were Dixon Ward with 524 (11.8%), Carlton-Coleby Ward with 511 (11.5%) and Johnson Ward/coronary care unit with 472 (10.6%).

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints

Trust level
From March 2018 to February 2019 the trust received 128 complaints about medicine (17.6% of total complaints received by the trust). The trust took an average of 58.7 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be dealt with within 35 working days, or 50 working days for more complex complaints.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>30</td>
<td>23.4%</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>26</td>
<td>20.3%</td>
</tr>
<tr>
<td>Patient care</td>
<td>22</td>
<td>17.2%</td>
</tr>
<tr>
<td>Admission &amp; discharges (excluding delayed discharge due to absence of a care package)</td>
<td>19</td>
<td>14.8%</td>
</tr>
<tr>
<td>Values and behaviour</td>
<td>7</td>
<td>5.5%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>7</td>
<td>5.5%</td>
</tr>
<tr>
<td>Privacy dignity and wellbeing</td>
<td>6</td>
<td>4.7%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>5</td>
<td>3.9%</td>
</tr>
<tr>
<td>Safeguarding - patient care</td>
<td>2</td>
<td>1.6%</td>
</tr>
<tr>
<td>Safeguarding - privacy dignity</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Safeguarding - values behaviours</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Total</td>
<td>128</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Breakdown by site can be seen below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital, Boston</td>
<td>61</td>
<td>47.7%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>57</td>
<td>44.5%</td>
</tr>
<tr>
<td>Grantham &amp; District Hospital</td>
<td>10</td>
<td>7.8%</td>
</tr>
<tr>
<td>Total</td>
<td>128</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Lincoln County Hospital**

From March 2018 to February 2019, Lincoln County Hospital received 57 complaints in relation to medicine. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>18</td>
<td>31.6%</td>
</tr>
<tr>
<td>Communication</td>
<td>14</td>
<td>24.6%</td>
</tr>
<tr>
<td>Patient care</td>
<td>10</td>
<td>17.5%</td>
</tr>
<tr>
<td>Values and behaviour</td>
<td>4</td>
<td>7.0%</td>
</tr>
<tr>
<td>Admission &amp; discharges (excluding delayed discharge due to absence of a care package)</td>
<td>4</td>
<td>7.0%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
<td>3.5%</td>
</tr>
<tr>
<td>Privacy dignity and wellbeing</td>
<td>2</td>
<td>3.5%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>3.5%</td>
</tr>
<tr>
<td>Safeguarding - privacy dignity</td>
<td>1</td>
<td>1.8%</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust

From March 2018 to February 2019, there were 9,032 compliments about medical care at the trust. A breakdown of compliments by site is below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>March 2018 to February 2019</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td></td>
<td>4,356</td>
<td>48.2%</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td></td>
<td>2,191</td>
<td>24.3%</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td></td>
<td>2,054</td>
<td>22.7%</td>
</tr>
<tr>
<td>County Hospital Louth</td>
<td></td>
<td>230</td>
<td>2.5%</td>
</tr>
<tr>
<td>Pan trust</td>
<td></td>
<td>201</td>
<td>2.2%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>9,032</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The trust noted that, alongside the compliments received by wards and services, there were an additional 746 comments recorded trust-wide. These were comments from patients, families and staff directly to the services and staff with whom they came in contact.

A theme from the compliments received trust-wide was good communication.

Lincoln County Hospital

From March 2018 to February 2019, there were 4,356 compliments about medicine at Lincoln County Hospital. A breakdown of compliments by department is below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>March 2018 to February 2019</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopy suite</td>
<td></td>
<td>618</td>
<td>14.2%</td>
</tr>
<tr>
<td>Dixon Ward</td>
<td></td>
<td>584</td>
<td>13.4%</td>
</tr>
<tr>
<td>Johnson/coronary care unit</td>
<td></td>
<td>408</td>
<td>9.4%</td>
</tr>
<tr>
<td>Ashby Ward</td>
<td></td>
<td>399</td>
<td>9.2%</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td></td>
<td>387</td>
<td>8.9%</td>
</tr>
<tr>
<td>Waddington Unit</td>
<td></td>
<td>337</td>
<td>7.7%</td>
</tr>
<tr>
<td>Navenby Ward</td>
<td></td>
<td>276</td>
<td>6.3%</td>
</tr>
<tr>
<td>Burton Ward</td>
<td></td>
<td>230</td>
<td>5.3%</td>
</tr>
<tr>
<td>Scampton Ward</td>
<td></td>
<td>216</td>
<td>5.0%</td>
</tr>
<tr>
<td>Lancaster Ward</td>
<td></td>
<td>207</td>
<td>4.8%</td>
</tr>
<tr>
<td>Frail assessment unit</td>
<td></td>
<td>175</td>
<td>4.0%</td>
</tr>
<tr>
<td>MEAU/MESS</td>
<td></td>
<td>165</td>
<td>3.8%</td>
</tr>
<tr>
<td>Medical day unit</td>
<td></td>
<td>161</td>
<td>3.7%</td>
</tr>
<tr>
<td>Carlton-Coleby Ward</td>
<td></td>
<td>116</td>
<td>2.7%</td>
</tr>
<tr>
<td>Cardiac short stay ward / catheter labs</td>
<td></td>
<td>77</td>
<td>1.8%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>4,356</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning had been identified following the death of a patient with a learning disability and the treatment of another patient. Learning disability grab bags were developed. The trust had also signed up to the Mencap ‘Treat me well’ campaign which calls upon NHS staff to make reasonable adjustments for people with a learning disability and learn from experts by experience.
Staff understood the policy on complaints and knew how to handle them. Staff we spoke were aware of the complaints policy and procedure and informed us that they tried to resolve any patient concerns immediately to prevent the concerns escalating to a complaint. Staff directed patients and visitors to PALS (Patient Liaison and Advice Service).

The service clearly displayed information about how to raise a concern in patient areas. Notice boards on the wards included ‘You said ’ ‘We did’, in response to patient comments. 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.

The Swan project was launched following a complaint about from a relative whose mother was end of life and was distressed by the level of the noise on the ward. Staff now place electric candles on the nurse’s station so that staff are aware that there is a patient on the ward that is end of life, they also used laminated signs with a picture of a swan behind the patient’s bed to create an awareness for staff to keep noise to a minimum.

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. However, whilst they understood the priorities and issues the service faced these were not always managed effectively. They were not always visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Specialist and acute medical services were organised into three clinical directorates within the integrated medicine business unit. Each clinical directorate had a triumvirate leadership team with a divisional clinical advisor, general manager and a head of nursing. Both the divisional clinical and visor and the general manager were interim posts at the time of our inspection.

Ward managers told us that they felt well supported by their senior teams. They were given opportunities to shadow them in their senior roles and had conversations about their own development.

There was a leadership development programme for managers including clinical staff. This covered a variety of modules. Modules included, people management, managing performance, managing finances and improving services.

Staff aware of the whistleblowing policy and many staff told us they would escalate concerns or challenge colleagues if patient safety was compromised.

Staff were knowledgeable about the ward’s performance against the trust priorities and the areas for improvement. This was helped by the trusts ward accreditation scheme.

Leaders understood the challenges to quality and sustainability in the service. However, access and flow performance within the service was poor and in some areas, significantly worse than the England average. We did not see where measures had been put in place to address this performance.

Most staff we spoke to felt supported and spoke positively about their managers and senior staff on the ward were also approachable. However, some staff told us that they didn’t feel valued or listened to and there was no inclusive working.
Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and set of values. The trust had set a five year “journey to excellence.” Focusing on valuing patient’s time and work alongside their staff and patients to develop ideas for continually improve the effectiveness and efficiency of the service.

Progress against delivery of the strategy and local plans were monitored through local and national audits and benchmarking against other providers. However, we were not assured progress was reviewed or appropriate actions taken to improve services. Outcomes for patients and timely access to care and treatment, in some areas, did not meet national standards and/or was worse than the England average.

The trust had a clear set of values which underpinned the strategic objectives. These values were developed by staff volunteers and patients. These values were:

- Patient-centred: Putting patients at the heart of everything, listening and responding to their needs and wishes.
- Safety: Following the trusts and the staff's own professional guidelines. Speaking up to make sure patients and staff were safe from harm.
- Excellence: Striving to be the best possible. Innovating and learning from others.
- Compassion - caring for patients and their loved ones in ways the trust would want for their friends and family
- Respect: Behaving and using language that demonstrated respect and courtesy to others. Zero tolerance to bullying, inequality, prejudice or discrimination.

The values formed part of the trusts recruitment and were included as part of staff appraisals.

During our inspection we saw staff work in line with the trust values. They treated staff patients and relatives with compassion. Behaved in an appropriate way without discrimination towards others.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they enjoyed caring for their patients and we observed good interaction during the inspection. Most staff felt supported by their colleagues and matrons in their individual areas.

Staff at all levels were clear about their roles and understood what they were accountable for. Nursing and medical staff knew who their manager was and who to report to. Most staff could identify their senior lead within the medical division.

Staff were committed and passionate about the care they provided to patients. Most staff felt that there were good working relationships in their clinical area between all MDT members.

Health and well-being initiatives were offered to staff. On some wards we saw posters for mindfulness sessions which staff were invited to attend.
Service leaders spoke highly of staff on wards and how hard they had worked and adapted to new initiatives such as the ward accreditation and new ways of working.

Staff were aware of the trust’s whistleblowing process and how to report and raise concerns. There was a Freedom to speak up Guardian, the role of the Guardian was included in staff inductions and had also been added as a presentation on the preceptorship programme for nurses.

There was a feeling of frustration and lack of feeling included amongst some non-clinical staff. They were repeatedly reporting faults and that there was no clear path for reporting them. When improvements were suggested they would be told they are too expensive.

Some staff said they were well supported at a local level but felt leaders did not always know what was happening at a frontline level.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

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.

The service had introduced a ward accreditation scheme, wards were assessed against a set of quality standards expected on the ward. This was an effective quality marker for managers. This identified any areas in performance that needed improving.

To help improve sepsis screening and management the hospital sepsis lead nurse practitioner had delivered training to all ward-based teams.

There was a trust management group that met twice a month. This was attended by the divisional clinical director, divisional lead nurse, divisional managing director and trust executives. One meeting focused on strategy, policy development and transformation and the second focused on delivery and risk. The deliver and risk meeting focused on issues and risks escalated from performance review meetings and the Quality and Safety Oversight Group (QSOG).

Monthly mortality review meeting took place these were attended well by all levels of medical staff across all the medical divisions. This included a review of patient deaths, serious incidents and complaints as tools to assess performance.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, however actions to reduce their impact were not always taken. They had some plans to cope with both the expected and unexpected.

Monthly meetings between staff on the endoscopy unit took place and included staff from endoscopy units at the other hospital sites (Pilgrim, Louth and Grantham). A need for support and improvement is identified at the meeting. During our inspection staff told us that staff from Louth hospital were working at Lincoln County Hospital as there had been some micro decontamination if the washers used to clean the endoscopy equipment which was awaiting repair. This outlined a potential issue to the staff at Lincoln. Although the decontamination washers were in good working
order they were over ten years old. A case had put forward including cost of replacement and this was awaiting to be agreed by management.

All wards had a safety and quality dashboard that was used to monitor risk, performance and quality. The dashboard provided an overall score and enabled ward teams to quickly identify where they needed to focus improvements and where they had achieved a high standard.

The trust had a business continuity policy which was reviewed in June 2016. The policy gave guidance on how to support departments in developing a resilient trust, in anticipating and reducing risks to minimise disruption when unplanned events significantly disrupted normal running of the service.

Each month there was a performance review meeting between executives and each division to check process on the delivery of priority objectives, agree actions where progress still needs to be made and provided any support that was required. Issues arising from these performance meetings were escalated to the relevant board committee and to the trust management group to monitor performance. This included discussions around harm free care, workforce, sustainable service, referral to treatment times and waitlists.

Divisional and service teams used risk registers to identify, track and monitor risks. However, it was not evident this was always effective at reducing risk or improving performance. Staffing was a consistent theme in every service throughout the risk register.

During our previous inspection, we found risks identified by the service were not being assessed, monitored and mitigated through an effective, comprehensive risk register. Risks were not reviewed and actioned in a timely way. Previously it was identified that the environment in the Ingham suite was no longer fit for purpose due to demands on the service. Mitigating actions had been put in to place but some issues still had not been resolved.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The divisional directors had oversight of all specialties within their division and escalated to the trust board appropriately. This enabled decision makers to have the relevant, up to date information to inform decisions being made about the service. Since March 2019 the trust had implemented a weekly escalation meeting established with a clinical pathology network, that operated across Lincolnshire, to prioritise work, examine opportunities to manage demand and ensure escalations were in place to help improve cancer wait times.

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

We saw computer systems were kept secure with a password log in. Information governance training was provided to all staff.

The trust had leaflets about “Lincolnshire’s care portal” this was a new secure computer system that provided health and care staff with a selected view of patient’s personal information contained in different health and care systems. This included, patients name, address, NHS Number and phone number, medications and allergies, test results, letters, treatment that had been received, future and past appointment and care plans. There was instruction on how to opt out of the service.
We did not always see that patient notes were stored securely. There were locked notes trolleys in use we found that notes were mostly stored here but the trolleys were not always locked.

**Engagement**

The trust engaged well with patients, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. Some staff felt that there was a lack of engagement from leaders.

A patient experience committee had an oversight of service improvements that could be submitted by any ward or clinical department and ensured improvements were based on service user need. Feedback from carers surveys, listening clinics, health watch feedback and friends and family tests were used to identify areas for improvement.

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.

We saw boards displaying the trusts values on some wards and in the corridors of the hospital. On one ward we saw staff had created a notice board with each staff members photograph and their job role, they were then easily identifiable to those visiting the ward.

The service website outlined how to contact the trust and information and telephone numbers for individual wards were available.

The trust had a social media page where they advertised and promoted current and upcoming events. During our inspection the trust were celebrating carers week, carers support services were advertised on social media and encouraged carers to ‘get connected.’

There was an ‘example of excellence’ scheme that recognised when staff had done something well or gone the extra mile.

Team meetings were in place across some wards. Some ward Managers had introduced a closed social media group to enable their staff to stay up to date with changes and new policies.

The trust had introduced a new operating model in April 2019. Staff were encouraged to attend one hour drop in sessions that were planned throughout the summer. This allowed that attended to gain an understanding of the new ways of working. We reviewed attendance records and saw that some of these had been cancelled due to lack of participants.

Staff commented on the amount of moves between ward areas that they have had to do in recent months. To help improve morale and towards ward moves, leaders told us that they advertised on social media an optional meeting that staff could have attended which was based on myth busting and helping to staff fell welcomed when they were moved to a ward that was not their usual place of work.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Healthcare assistants were offered the opportunity to progress to progress and learn. For new starts there was the care certificate that could be completed. The trust is strengthening their workforce but the employment of Advanced Clinical Practitioners (ACPs) and Advanced Nurse Practitioners (ANPs) there were areas where these were already in place. Ingham ward had recently recruited two ANPs one was already in post at the time of our inspection and one was yet
to start. There were two gaps in medical staffing numbers due to maternity and sickness. It was felt that these roles would help support the medical and nursing workforce.

There was a variety of new roles that leaders told they were incorporating into the recruitment plan. This included, trainee nursing associates (TNAs) and international return to practice nurses (IRTPs).

Audits showed that there was a continual drive to identify opportunities for improvement and innovation in care and treatment, with a focus around patient experience and outcomes.

Staff on the endoscopy unit felt that they were encouraged to be developed. They offered rotational posts within the unit to help with professional development.

There had been positive improvements around patients with learning disabilities, we saw across all wards that ‘this is me’ booklets were being used. Staff also had an awareness of patients needs and there was an online training package that staff could do. One ward was promoting learning disability week with a daily bulletin that covered a different topic each day.

Senior teams were in the early stages of integrating remote video technology to enable staff working cross-site to meet and communicate more easily. This enabled matrons working in the new structure to work cross-site and maintain regular contact with their teams.

The trust had been successful in attracting clinical trials, developing its clinical research infrastructure and attracting funding from the National Institute for Health Research (NIHR). However, the trust had not been successful in attracting research grants and promoting collaborative research with other organisations, particularly with the University of Lincoln. There was a new research strategy in place which outlined how the trust will work in partnership with key stakeholders to achieve its clinical research objectives.
Facts and data about this service

The trust has 33 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, United Lincolnshire Hospitals NHS Trust and England

This trust

- Neonatal, 8.1%
- Adult, 93.9%

England

- Neonatal, 24.1%
- Pediatric, 5.5%
- Adult, 70.3%

(Source: NHS England)

Descriptions of the critical care service at each site at the trust is below:

Lincoln County Hospital

The hospital has an intensive care unit with 16 beds to manage level 2 (HDU) and level 3 (Intensive Care Unit (ICU)) critically ill patients. The unit is staffed by a team of consultant intensivists supported by registrars on rotation from Nottingham and Leicester. The nursing staff are led by a team of senior nurses.
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 service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training, with the exceptions of:

- Fraud awareness and infection prevention level one, which had targets of 95%.
- Local fire procedures and fire safety, which had targets of 100%.
- Immediate life support (ILS)/advanced life support (ALS) and medicine management training which had no targets. The trust informed us that the eligible numbers of staff were not available for these two courses and therefore we were unable to calculate completion rates.

Trust level

A breakdown of compliance for mandatory training courses as of February 2019 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and diversity</td>
<td>112</td>
<td>116</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>111</td>
<td>116</td>
<td>95.7%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>111</td>
<td>116</td>
<td>95.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>110</td>
<td>116</td>
<td>94.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>109</td>
<td>116</td>
<td>94.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>108</td>
<td>116</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>108</td>
<td>116</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>108</td>
<td>116</td>
<td>93.1%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>108</td>
<td>116</td>
<td>93.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>105</td>
<td>116</td>
<td>90.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>102</td>
<td>116</td>
<td>87.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>36</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>72</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

In critical care the target was met for seven of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.
A breakdown of compliance for mandatory training courses as of February 2019 at trust level for medical staff in critical care is shown below: In critical care the target was met for five of the 11 mandatory training modules for which medical staff were eligible.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>14</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>13</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>13</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>13</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>13</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>13</td>
</tr>
<tr>
<td>Basic life support</td>
<td>13</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>12</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>12</td>
</tr>
<tr>
<td>Information governance</td>
<td>12</td>
</tr>
<tr>
<td>Fire safety</td>
<td>12</td>
</tr>
</tbody>
</table>

Nursing staff received and mostly kept up to date with their mandatory training.

**Lincoln County Hospital critical care department**

A breakdown of compliance for mandatory training courses as of February 2019 for qualified nursing staff in the critical care department at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>64</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>63</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>63</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>63</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>62</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>62</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>61</td>
</tr>
<tr>
<td>Fire safety</td>
<td>60</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>60</td>
</tr>
<tr>
<td>Basic life support</td>
<td>57</td>
</tr>
<tr>
<td>Information governance</td>
<td>55</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>29</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>33</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital’s critical care department, the target was met for six of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

Medical staff received and mostly kept up to date with their mandatory training.

A breakdown of compliance for mandatory training courses as of February 2019 for medical staff in the critical care department at Lincoln County Hospital is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>8</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>8</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>7</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>7</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>7</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>7</td>
</tr>
<tr>
<td>Fire safety</td>
<td>7</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>7</td>
</tr>
<tr>
<td>Basic life support</td>
<td>7</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>6</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital’s critical care department, the target was met for two of the 11 mandatory training modules for which medical staff were eligible. However, the completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.

The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with informed us training included relevant information and guidance to provide them with skills to support patients. Fluid balance E-learning training was also provided by the Critical Care Outreach Team (CCOT) as part of mandatory training, which had been in place since January 2019 to support staff in this area.

Staff completion on Sepsis management training was 94%. Staff we spoke with stated they had received annual training on sepsis management which included the use of sepsis screening tools and use of the sepsis care bundle.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning, disabilities, autism and dementia. Staff told us they had completed training which provided them with awareness on supporting patients with these needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff who were not up to date with their mandatory training were booked onto courses to complete it. Staff also reported they had protected time to complete mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

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

Trust level

A breakdown of compliance for safeguarding training courses as of February 2019 at trust level for qualified nursing staff in critical care is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>101</td>
<td>116</td>
<td>87.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>101</td>
<td>116</td>
<td>87.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>100</td>
<td>116</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>100</td>
<td>116</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care the 90% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible. However, at the time of our inspection 97% of staff had completed their safeguarding training.

A breakdown of compliance for safeguarding training courses as of February 2019 at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care the 90% target was not met for any of the four safeguarding training modules for which medical staff were eligible.

Nursing staff received training specific for their role on how to recognise and report abuse.

**Lincoln County Hospital critical care department**

A breakdown of compliance for safeguarding training courses as of February 2019 for qualified nursing staff in the critical care department at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>60</td>
<td>64</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>60</td>
<td>64</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>60</td>
<td>64</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>60</td>
<td>64</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital’s critical care department, the 90% target was met for each of the four safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of February 2019 for medical staff in the critical care department at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
At Lincoln County Hospital’s critical care department, the 90% target was not met for any of the four safeguarding training modules for which medical staff were eligible. However, completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff received training to make them aware of the potential needs of people with mental health conditions, learning disability, autism and dementia. Staff told us about a patient with a mental health condition, and how they protected them after they self-prescribed medication. Staff supported the patient and sensitively respected their needs. We observed staff protecting patients from discrimination and treating them equally throughout our inspection.

Effective safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff. Including development at a local level bespoke to ICU patients. For example, the ligature risk assessment and enhanced care bundle developed for patients with mental health conditions, those living with dementia or a learning disability.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with informed us of the ICU safeguarding folder, which they accessed if required for guidance or information on protecting adults or children at risk of, or suffering, significant harm. Staff worked with other agencies including the local authority safeguarding team, hospices, and General Practitioners (GPs) for patient history and to share information. Staff also worked with the trust palliative care team and mental health services to protect patients.

The trust had a process for recording and reporting women or children with, or at risk of Female Genital Mutilation (FGM). The trust initiated the National alerting system for FGM. There was a section within the safeguarding pages on the trust’s intranet to remind staff of their responsibilities in relation to FGM reporting and management. Staff told us they received training on FGM and knew the process to follow.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had safeguarding systems, processes and practices in place to keep people safe, which were communicated to staff and appropriately implemented. Staff we spoke with confirmed the process to follow to make a safeguarding referral, including informing the nurse in charge, making a referral directly to the local authority safeguarding team, or seeking advice from the trust safeguarding lead.

Staff followed safe procedures for children visiting the ward. One staff member informed us they were concerned for the well-being of a child visitor and completed a safeguarding referral for them.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained. Facilities managed the cleaning of the unit, and it was thorough to control infection. We observed staff working together to maintain the cleanliness of the environment.
There was a system in place to monitor standards of cleanliness in line with the Department of Health National Standard of cleanliness. For example, cleaning audits for April 2019 showed 95% compliance. Hand hygiene audits for May 2019 demonstrated 100%. From December 2018 to April 2019 the trust reported one hospital acquired infection, this was Clostridium Difficile (C. diff) Glutamate Dehydrogenase (GDH) positive. C. diff is a bacteria present in the bowel, and GDH is a chemical found in C. diff These figures were displayed on a noticeboard for staff, patients and relatives.

**Cleaning records were up to date and demonstrated that all areas were cleaned regularly.**

Daily cleaning was completed and recorded by staff on the unit.

**Staff followed infection control principles including the use of personal protective equipment (PPE).** Suitable PPE was available around each bed, and we observed staff consistently used it in line with best practice guidelines.

We observed all staff followed policy and adhered to ‘bare below the elbow’. We also saw a reminder poster displayed for staff before entering the unit, which included detail on what ‘bare below the elbow’ meant. Staff carried out hand hygiene such as hand washing and using hand sanitising gel.

A piece of work was undertaken by the trust between January and March 2019 (quarter four) which changed the way in which hand hygiene was assessed. Prior to this the trust would receive consistent 100% hand hygiene compliance in most areas and recognised that this probably did not reflect actual practice. The trust therefore changed the hand hygiene assessment methodology to better reflect a more accurate position and to show the areas where non-compliance needed support. During quarter four, the infection prevention and control (IPC) team briefed the trust IPC committee to advise that they expected hand hygiene numbers to decline as the new assessment tool was rolled out. This guided the IPC team on where they needed to focus their efforts to support improvements.

**Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.** We saw staff thoroughly cleaned equipment for infection control and used ‘I am clean’ stickers to show it had been cleaned.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe.**

**Staff were trained to use them. Staff managed clinical waste well.**

Patients could reach call bells and staff responded quickly when called. One patient we spoke with told us staff came immediately when called. We also saw staff consistently responded to patients.

The design of the environment followed national guidance. There was adequate space between each bay to allow multiple staff to support a patient when required, the ward lead told us the service complied with bed regulations and we observed each bed area was 25 meter squared.

Staff carried out daily safety checks of specialist equipment. Safety checks were carried out at the start of every shift. The equipment within the resuscitation trollies were in date and were checked daily by staff.

The unit trained staff on equipment to ensure to keep people protected from avoidable harm. The clinical educator supported staff with equipment competencies. This included completion of performance standards for each member of staff. During our inspection, we saw staff received training on a new piece of equipment the service was trialling, a cooling device for postcardiac patients.
The service had a back-up plan for the event of an IT (Information Technology) failure. The plan was included in the business continuity policy and action plan, which also planned for a cyber-attack.

The service had suitable facilities to meet the needs of patients’ families. The service had a very calming atmosphere throughout our inspection. During our third day the unit had an increased number of level three patients, this did not impact on the feel of the environment, and the calming atmosphere remained. Visiting hours were open and relatives were encouraged to book a visiting time after the ward round, due to the service operating a ‘two per bed’ policy. The unit had two relatives’ rooms which patients’ families used to provide them with privacy and an area away from the bays if required.

The service had enough suitable equipment to help them to safely care for patients. We reviewed 15 pieces of equipment, all were maintained and up to date with service tests. Services were provided in house by a clinical engineering service. We saw oxygen cylinders were stored correctly and appropriately. However, only eight out of 20 ventilators had been replaced. The local managers told us the funding had been pulled for the replacement programme, and the remaining replacements were all in date for approximately one year.

Staff disposed of clinical waste safely. It was managed effectively and was collected regularly by porters who removed it to the correct place to prevent any build up.

**Assessing and responding to patient risk**

*Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.*

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff could access patient notes quickly in case any change to their medical condition occurred. Nursing staff provided immediate care for deteriorating patients and requested urgent support from a band 7 or immediate input from a doctor. Staff told us that there was always someone senior around for to support them. The critical care unit continued treatment for critically ill patients with sepsis. Staff continuously monitored the vital signs of patients.

As recommended by NHS England, the service had developed local safety standards for invasive procedures (LocSSIPs). The standards set out the key steps necessary to deliver safe care for patients undergoing invasive procedures. The ACCP (Advanced Critical Care Practitioner) had developed and shared knowledge on LocSSIPs. For example, we saw one record had a completed invasive procedure checklist for a central venous catheter insertion and for a nasogastric tube insertion.

Staff completed risk assessments for each patient on admission and updated them when necessary using recognised tools. Records we reviewed showed staff completed and updated risk assessments for each patient, these included a physiotherapy assessment, and occupational therapy assessment. They kept clear records and asked for support when necessary. Staff used tools including the Venous Thromboembolism (VTE) risk assessment tool, MRSA screening tool and a Pressure Area Risk Assessment Chart (Waterlow) assessment to assess patient risk.

Staff knew about and dealt with any specific risk issues. The critical care outreach team contributed vitally to assessing and responding to patient risk. The team provided 24-hour service seven days a week. They provided formal and informal education and support to nursing, medical and allied health professional staff to manage any concerns. The critical care outreach team responded to 87% of HIT (High level Intensity Team) calls, for NEWS (National Early Warning...
Score) equalling seven or more that were escalation to level 2 or 3. The critical care outreach team completed initial assessments and triaged patients, they also had oversight of patients due to be transferred and visited patients before discharged from ICU.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). The critical care outreach team directly referred patients who were feeling stressed, unhappy, depressed, sad, worried or anxious, onto ‘Steps2change’ for short term therapy. The service also made referrals to the trust mental health liaison team, and the crisis team when out of hours.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The unit had developed a ligature risk assessment policy as part of their improvements. The risk assessment included both the assessment and management of ligature risks through five sections. The sections comprised of the clinical area, the most recent ligature point audit tool, a ligature action plan, the local management plans and the standard operating procedure for ligature cutters.

Staff shared key information to keep patients safe when handling over their care to others. The unit had daily safety huddles which ensured key patient information was shared across all staff disciplines. We saw medical staff received updates from nursing staff at patient bed sides, which included up to date information on patients. CCOT also developed an SBAR communication tool to share information among stuff. This was filed in medical notes.

Shift changes and handovers included all necessary key information to keep patients safe. Staff ensured continuity of care as they completed thorough handovers making sure all relevant staff received up to date correct information on each patient. We saw staff handovers had input from consultants, registrars, nurses, critical care outreach team, nursing staff, pharmacy, physiotherapist and the advanced critical care practitioner (ACCP).

A pharmacist was not always available for handover, and therefore could not have consistent oversight on each patient.

National Early Warning Score (NEWS) 2 was not used routinely because patients were under continuous clinical observation, however if patients were fit for ward care, NEWS 2 was used for the last 24 hours of the patients stay on the ICU. This gave the ward a baseline.

### Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

#### Trust level

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for critical care.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>63.7</td>
<td>72.4</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>47.5</td>
<td>47.1</td>
</tr>
<tr>
<td>Total</td>
<td>111.2</td>
<td>119.4</td>
</tr>
</tbody>
</table>
From April 2017 to March 2018, the nursing staffing rate within critical care was 93.2%. This was higher than the rate of 89.8% in the more recent period from April 2018 to February 2019.

Lincoln County Hospital

Lincoln County Hospital only has the one reporting unit for critical care and the staffing data for this unit is detailed above.

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

The service had enough nursing staff of all grades to keep patients safe. The unit had consistently good monitoring and oversight of every patient regardless of acuity level, rotas we reviewed for 1-18 June showed whilst planned staffing levels did not meet the actual staff levels in line with the unit requirements, we saw where there was an appropriate number of staff to meet the acuity levels of patients during this period. The planned nurse staffing was 13 registered nurses for early, late and night shifts. The registered nurses included clinical nurse educator, ward manager, supernumerary registered nurses and health care assistants.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. In accordance with national guidance. The staffing level and skill mix was reviewed daily. Patient acuity was reviewed three times per day, at 8:30am, 12pm and 3:30pm, with a predicted review given the end of each day.

The ward manager could adjust staffing levels daily according to the needs of patients. The ratio of nurse to patient was consistently in line with GPIC (Guidelines for the Provision of Intensive Care services) standards. Staffing levels were monitored and the impact on safety was assessed. Staffing level was discussed at handover which included nurse and medical staffing, CCOT, pharmacy and therapy.

The number of nurses and healthcare assistants on all shifts did not match the planned numbers. However, we reviewed in detail three days of nurse to patient ratio and we found whilst actual levels were lower than planned, nurse to patient ratio was in line with Intensive Care Society (ICS) standards. For example, on 18 June 2019 there were 12 registered nurses on shift during the day and the night with the patient acuity of four level three, seven level two and one level one patient, this meant at least eight registered nurses were required. On 17 June 2019 there were 12 registered nurses on the day shift and 11 on the night with the patient acuity of two level three, five level two and two level one patients, this meant at least five and half registered nurses were required. 16 June 2019 there were 10 registered nurses with one associate practitioner on the day shift and 11 registered nurses on the night with the patient acuity of three level three, seven level two and one level one patient, this meant at least seven registered nurses were required. Therefore, across all three days of our inspection there were enough registered nurses to meet the acuity needs of each patient on the critical care unit at this time.

We spoke with physiotherapists, who felt there was enough staff to meet the needs of patients on the critical care unit.

The speech and Language therapy service was provided by a local NHS trust.

The dietetic services did not provide a dedicated service for the critical care unit.

Vacancy rates

Trust level
From April 2018 to March 2019, the trust reported a vacancy rate of 8.6% for nursing staff in critical care. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital critical care department: 10.8%
- Pilgrim Hospital critical care department: 5.7%

A breakdown of vacancy rates by ward for each site is below

**Lincoln County Hospital**

There is only one reporting unit for Lincoln County hospital and the rate for this unit is detailed above.

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

The service had low and reducing vacancy rates. At the time of our inspection, service leaders told us the vacancy rate had reduced from 10.8%, as recorded from the period April 2018 to March 2019, to 2.2%.

**Turnover rates**

The service had turnover rates at or below the trust target.

**Trust level**

From April 2018 to March 2019, the trust reported a turnover rate of 4.7% for nursing staff in critical care. This was lower than the trust target of 8%.

- Lincoln County Hospital critical care department: 4.0%
- Pilgrim Hospital critical care department: 5.7%

**Lincoln County Hospital**

There was only one unit in Lincoln which had turnover recorded from April 2018 to February 2019 and the rate for this is detailed above.

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

**Sickness rates**

The service had sickness rates at or below the trust target.

**Trust level**

From April 2018 to March 2019, the trust reported a sickness rate of 4.5% for nursing staff in critical care. This was the same as the trust target of 4.5%.

- Lincoln County Hospital critical care department: 4.2%
- Pilgrim Hospital critical care department: 5.0%

A breakdown of sickness rates by ward for each site is below.
Lincoln County Hospital

There was only one unit in Lincoln which had sickness recorded from April 2018 to February 2019 and the rate for this is detailed above.

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

Bank and agency staff usage

The service had low and reducing rates of bank and agency nurses used on the unit.

Trust level

The table below shows the numbers and percentages of nursing hours in critical care at trust level from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 233,513 total working hours available, 2.8% were filled by bank staff and 3.3% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 11.5% of the available hours with either bank or agency staff.

Of the 24,345 total working hours available, 27.1% were filled by bank staff and 0.0% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 47.2% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2018 to February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Qualified staff</td>
<td>233,513</td>
<td>6,603</td>
<td>2.8%</td>
<td>7,636</td>
<td>3.3%</td>
<td>26,852</td>
</tr>
<tr>
<td>Non-qualified staff</td>
<td>24,345</td>
<td>6,595</td>
<td>27.1%</td>
<td>0</td>
<td>0.0%</td>
<td>11,482</td>
</tr>
</tbody>
</table>

Lincoln County Hospital

The table below shows the numbers and percentages of nursing hours in critical care at the one critical care unit in Lincoln County Hospital from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 141,512 total working hours available, 2.6% were filled by bank staff and 5.3% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 10.2% of the available hours with either bank or agency staff.

Of the 15,624 total working hours available, 37.0% were filled by bank staff and 0.0% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 42.0% of the available hours with either bank or agency staff.
Managers limited their use of bank and agency staff and requested staff familiar with the service. There was minimal use of agency staff, during absence, the unit was covered by staff working overtime.

Managers made sure all bank and agency staff had a full induction and understood the service. Although agency staff were minimal, where they were used we saw evidence of an induction and competencies completed.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

**Trust level**

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for critical care.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>9.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>7.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Total</td>
<td>16.0</td>
<td>18.0</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the medical staffing rate within critical care was 89.0%. This was higher than the rate of 83.4% in the more recent period from April 2018 to February 2019.

As there was only one team based at each site, these are represented in the site breakdown above.

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

**Trust level**

From April 2018 to March 2019, the trust reported a vacancy rate of 18.9% for medical staff in critical care. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital critical care department: 16.5%
- Pilgrim Hospital critical care department: 21.9%

Both sites just had the one department reporting vacancies. These are detailed above.
**Turnover rates**
The service had turnover rates for medical staff at or below the trust target.

**Trust level**
From April 2018 to March 2019, the trust reported a turnover rate of 10.0% for medical staff in critical care. This was higher than the trust target of 8%. The trust has reported that their turnover data for medical staff includes trainee grades which may have inflated the rate.

- Lincoln County Hospital critical care department: 5.9%
- Pilgrim Hospital critical care department: 15.4%

Both sites just had the one department reporting turnover. These are detailed above.

**Sickness rates**
Sickness rates for medical staff were at or below the trust target.

**Trust level**
From April 2019 to March 2019, the trust reported a sickness rate of 2.4% for medical staff in critical care. This was lower than the trust target of 4.5%.

- Lincoln County Hospital critical care department: 0.9%
- Pilgrim Hospital critical care department: 4.3%

Both sites just had the one department reporting sickness. These are detailed above.

**Bank and locum staff usage**
The service had low and reducing rates of bank and locum staff used on the wards. The unit had not been covered by locum staff for the previous three years.

Please note that the trust confirmed that they were unable to provide accurate establishment hours by department and location in all cases. Therefore, we have not calculated the proportion of hours filled by bank and locum staff or left unfilled as this may be misleading.

**Trust level**
The table below shows the number of medical hours in critical care at site level from April 2018 to February 2019 that were covered by bank and locum staff or left unfilled.

Over this time period, 2,775 hours were filled by bank staff and no hours were covered by locum staff to cover sickness, absence or vacancy for medical staff. The trust was not able to fill 487 of the available hours with either bank or locum staff.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank usage</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>2,775</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,775</strong></td>
</tr>
</tbody>
</table>
Lincoln County Hospital

As there was only one team based at this site, the table above shows the number of medical hours in critical care at Lincoln County Hospital from April 2018 to February 2019 that were covered by medical and locum staff or left unfilled.

Over this time period, 2,775 were filled by bank staff and no hours were covered by locum staff to cover sickness, absence or vacancy for medical staff. The trust was unable to fill 265 of the available hours with either bank or locum staff.

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

The service had enough medical staff to keep patients safe. The unit met the guidelines for the Provision of Intensive Care Services. For example, the critical care unit was led by intensive care consultants. The unit had eight consultant intensivists, with two vacancies. Two consultants covered a 24-hour period ensuring there was always a consultant on duty for the unit. The consultant to patient ratio was in line with the core standards for intensive care units, as there was always one consultant for 15 patients or less. The unit had junior doctor cover at tier one and tier two levels.

Managers could access locums when they needed additional medical staff. Staff informed us this was very rare, as they had not covered shifts with locum staff for three years.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The consultants covered from two to four days in a row to maintain continuity of care for patients and reviewed patients daily. The medical staff attended the daily multidisciplinary ward handover meeting and carried out a morning ward round. The ACCP provided care on the unit four days a week. This ensured ICU residents were of minimum seniority.

The service always had a consultant on call during evenings and weekends. This ensured a consultant in intensive care medicine was available 24 hours a day seven days a week.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. We reviewed in detail three patient records, all were completed thoroughly, were legible and were up to date. The patient notes were contained in a file, in a drawer, at the end of patient beds, they were well organised and included clinical reports, risk assessments, care plans and clear treatment plans which were reviewed daily.

When patients transferred to a new team, there were no delays in staff accessing their records. We saw all information needed for patient ongoing care was shared appropriately, in a timely way and in line with relevant protocols. Staff used the Mid Trent Critical Care Network Transfer form. This form was a legal record of transfer used for all level two and three patient transfers.

Records were stored securely. All records we reviewed were always insight of the registered nurse and kept safely in a drawer at the end of patient beds.

Most records were paper based, the trust has secured funding to change from paper-based Health Records to Electronic Health Records and expect completion will be in five to 10 years. The unit planned to use an electronic system along with Pilgrim Hospital critical care unit to assess patients...
and manage their care including administration of medicines. This was planned to be in place by the end of the financial year.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed eight medicine charts, all evidenced that medicines were safely prescribed and administered.

Local microbiology protocols for the administration of antibiotics were in use. In line with Trust protocols, when patients’ were prescribed an antimicrobial they had a microbiological sample taken and their treatment reviewed when results were available. A microbiologist was in attendance on the ward round once a week and staff had telephone access to external microbiologist support 24 hours a day, seven days a week.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. The Trust’s critical care pharmacist and other clinical pharmacists visited the unit to review patients’ medicines. However, the pharmacy service fell below the standards of GPICS (Guidelines for the Provision of Intensive Care Services) as the critical care pharmacist spent two days per week on the unit, as opposed to a minimum of five days pharmacy cover per week as advised by the guidance. Nurses we spoke with did not know when other pharmacists were coming, and there was no evidence of a rota on the unit. However, the pharmacist had a trainee pharmacist with the intention to fulfil this role to meet the standards.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. We saw evidence of appropriate storage of medicines in the clinic room, medicines were all stored safely and neatly in locked cupboards which followed standards. Controlled drugs were recorded effectively, and a recent audit, managed by the critical care pharmacist, showed 100% compliance up to 17 June 19.

The service had three fridges in the drug storage room, all temperatures were monitored and recorded. The drug storage room also had an air conditioning unit.

Staff followed current national practice to check patients had the correct medicines. We saw patients’ medicines were reviewed by medical staff with input and advice from pharmacists.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff were aware of the process for reporting incidents. No examples of shared learning from incidents were seen.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Medicines for sedation were used appropriately in response to clinical need.

**Incidents**

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
All staff knew what incidents to report and how to report them. Staff we spoke with confirmed they knew how to report an incident, using the trust's incident reporting system. Staff told us when they reported an incident, they received feedback. Staff also informed us they would inform the ward leader if there was a concern they wanted further advice.

Staff reported all incidents that they should report. Staff also reported safeguarding incidents to the nurse in charge and the trust's safeguarding lead.

**Never Events**

The service had no never events on the unit.

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

From March 2018 to February 2019, the trust reported no never events for critical care.

(*Source: Strategic Executive Information System (STEIS)*)

Managers shared learning with their staff about never events that happened elsewhere. Staff confirmed they received information through emails on shared learning.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from March 2018 to February 2019.

A breakdown of the serious incidents by type is shown in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer</td>
<td>5</td>
<td>55.6%</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>2</td>
<td>22.2%</td>
</tr>
<tr>
<td>HCAI/infection control incident</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>9</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Lincoln County Hospital**

In accordance with the Serious Incident Framework 2015, Lincoln County Hospital reported one serious incident (SIs) in critical care which met the reporting criteria set by NHS England from March 2018 to February 2019:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(*Source: Strategic Executive Information System (STEIS)*)

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff told us they were supported in
doing the right thing. For example, staff informed us of applying duty of candour when an incident had occurred with a patient from theatre, who transferred onto the unit. Staff from both services including surgeons and doctors within ICU applied duty of candour. Another example included an incident form being raised for a patient due to pressure damage to the inner right nostril, from an NG (Nasogastric) tube, evidence of written duty of candour was in the patient notes.

The service had applied duty of candour seven times between March 2018 and March 2019, the matron and ward manager told us these were all for moderate harm. We also asked managers about the above incident, we were told they had not reported any serious incidents, this was a mistake, and was for Grantham hospital not Lincoln County.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback through emails.

Staff met to discuss the feedback and look at improvements to patient care. Staff told us they had monthly meetings where incidents were discussed. Incidents were also discussed during daily multidisciplinary handover meetings and during the safety huddles. A noticeboard outside the staff room had details of the unit incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The matron and ward managers led on incident investigations with input from staff. Monthly governance meetings held discussions on incidents, investigations, and feedback.

Managers debriefed and supported staff after any serious incident.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

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 three new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from March 2018 to March 2019.

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

![Graph showing prevalence rate of pressure ulcers from March 2018 to March 2019]

1 Pressure ulcers levels 2, 3 and 4
Safety thermometer data was displayed on the critical care unit for staff and patients to see. The noticeboard highlighted the trust delivered 100% harm free care in May.

The safety thermometer data showed the services achieved over 95% harm free care for the last 12 months.

Staff used the safety thermometer data to further improve services. Results were discussed at monthly risk and governance meetings. The notice board demonstrated it had been 31 days since the last hospital acquired pressure ulcer, and what they had done to result in improved patient care. This included pressure relieving mattresses for all patients, at least four hourly pressure area care, the use of specialised sheets to relieve pressure from devices and the use of Nasogastric / Non-Invasive Ventilation (NIV) masks.

The noticeboard at the time of our inspection (18 June) also demonstrated the last fall on the unit was 5 June 19, and what they had done to result in improved patient care. This included completion of falls risk assessments, the delivery of new prescription charts, and least twice daily consultation reviews.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance, which managers checked to make sure staff followed. The service followed national guidance including the guidelines for the provision of intensive care services (GPICS) and the National Institute for Health and Care Excellence (NICE). Practice was in line with the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM).

Lincoln County Hospital critical care team was part of the Mid Trent critical care network and was active in the development of guidelines for critical care. The Mid Trent network fed into the national critical care network, ensuring the service was always up to date with current critical care best practice.

The service assessed people’s physical, mental health and social needs holistically. For example, staff assessed patient needs on admission to the unit, we saw NICE guidelines were followed for patients receiving Intravenous (IV) fluid therapy and patients were assessed to be at risk of VTE in accordance with NICE guidance.

At handover meetings, we observed staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. The service ensured a well-structured handover, which included staff from all disciplines, and a thorough discussion of all patients, with x-ray images viewable on screens. The handover provided input from consultants and patient specialists of care from the last four days, this ensured continuity of care for patients. Each patient was discussed in detail including their medical condition, emotional well-being and social circumstances.
Staff followed best practice as patient needs were continuously assessed in line with national guidance. For example, we saw staff assessed patients using MUST (Malnutrition Universal Screening Tool). Records also documented use of recognised tools such as MRSA screening, assessment of waterlow and catheter care bundle.

The service delivered care, treatment and support in line with legislation, standards and evidence-based guidance. For example, the unit provided a follow up clinic which supported patients with rehabilitation after critical illness, this followed evidence-based practice in line with NICE guideline Clinical Guideline 83. The clinical nurse educator also provided training and support for staff to deliver care and treatment in line with national guidance.

Processes were in place to ensure there was no discrimination, including those under the grounds of protected characteristics under the equality act, when making care and treatment decisions. For example, staff had received equality and diversity training and admission documents identified where patients had a protected characteristic.

The service used technology and equipment to enhance the delivery of effective care and treatment to support people’s independence. For example, the unit had a piece of ultrasound equipment which enabled a timely patient discharge in line with GPIC standards as a scan could be completed on the unit.

The Critical Care Outreach Team (CCOT), also used technology to deliver effective care and treatment, as based the HIT (High Level Intensive Team) service on NICE guideline 50, which CCOT provided regular reports on. Evidence from a 2018 report, dated February 2019, found that by independently managing the majority of HIT calls, CCOT reduced the need for the attendance of the ICU registrar, saving up to 27 hours of senior medic time a week.

The Advanced Critical Care Practitioner (ACCP) had a FICM membership, which featured in the GPIC standards. They demonstrated effective use of LocSSIPs to ensure staff followed best practice and completed ongoing audits to identify an improving picture, including, venous line care and nasogastric intubation. The ACCP presented these at the British Association for Critical Care Nurses (BACCN) and was due to present at the Mid Trent critical care network.

The trust measured compliance with the national standards through local audits presented to the monthly clinical governance meetings. Clinical audits included a ventilator audit looking at volume being ventilated. The service was looking at starting an audit of sepsis bundles with the trust’s sepsis lead, however this was not in place at the time of our inspection.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We spoke with nursing staff who demonstrated understanding and regard to the mental health act. Staff gave examples of actions taken to support patients with mental health concerns. Staff also referred patients with mental health concerns to the trust mental health liaison service, or to the mental health crisis team if out of hours. Staff further protected patient rights, by respecting their confidentiality, and supporting them whilst waiting for specialist support.

The service told people when to seek further help and advised what to do if their condition deteriorated. For example, the service followed the guidelines for the Provision of Intensive Care Services to screen all patients for delirium. We saw staff assessed patients for delirium when they completed observations. The unit also offered further support as CCOT completed follow up assessments when patients were transferred to the wards.

We saw sepsis screening and management was done effectively in line with NICE guideline 51. Staff were also appropriately training on the sepsis screening tool and care bundle.
Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs. Staff made sure patients had support with nutrition and hydration to meet their needs. We saw staff supported patients with eating and drinking during meal times and throughout the day. The service made a response to the trust pledges to avoid interrupting meal times without good cause. The Housekeeper was very focussed on nutrition and hydration, they tried their best to ensure patients received what they wanted to eat and drink at a time to suit them.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed five patient records and saw staff had carried out reviews of patients’ nutritional and hydration needs. Where patients could not take fluid or food orally staff clearly documented this in their records.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff assessed patients using MUST (Malnutrition Universal Screening Tool) this was recorded in their patient notes.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. The dietician was hospital-based Monday -Friday, however they did not review patients the day of referral. The pharmacist could refer to the dietician when required. Referrals for speech and language therapists were made to a neighbouring trust over the phone, on a messaging service. Staff stated that it could be at least three days before patients were seen. One nurse was trained to complete swallow assessments as these were more complex. Once the assessment had been completed staff could lead weaning patients onto foods, however patients were not getting post 48-hour intubation swallow assessments. Staff told us there was a national shortage in speech and language therapists.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Acute pain management was supervised by consultants and specialist nurses with appropriate training and competencies. We observed staff asked patients for patient date of birth and if they were allergic to anything before administering pain relief. For patients who had difficulty communicating staff used spell and action boards. This enabled patients to point directly at their pain score, or spell words out. Staff also recognised facial expressions and body movement including muscle tension to identify patient pain score.

Patients received pain relief soon after it was identified they needed it or they requested it. We observed staff administering pain relief to patients in a timely manner. One patient stated staff were very responsive to providing pain relief when required. We also observed staff checking pain levels with patients and asking if they were comfortable.

Staff prescribed, administered and recorded all pain relief accurately. All patients with acute pain had regular pain assessments, staff consistently used validated tools. Staff used a basic pain
score from 0-3 and recorded the results on a chart. Staff recorded any medicines prescribed for pain relief on their medicine chart.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

**ICNARC Participation**

The trust has two units which contributed to the Intensive Care National Audit Research Centre (ICNARC) – the Intensive Care Units at Lincoln County Hospital and Pilgrim Hospital. This meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

**ICNARC results**

**Lincoln County Hospital**

The table below summarises performance at the Intensive Care Unit at Lincoln County Hospital in the 2017/18 ICNARC Audit.
<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude non clinical transfers (Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)</td>
<td>1.1%</td>
<td>Within expected range</td>
<td>×</td>
</tr>
<tr>
<td>Crude, non-delayed, out-of-hours discharge to the ward proportion (Discharge out-of-hours is associated with increased risk of mortality)</td>
<td>1.4%</td>
<td>Within expected range</td>
<td>×</td>
</tr>
<tr>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours) (Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day)</td>
<td>1.4%</td>
<td>Not in the worst 5% of units</td>
<td>×</td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio (all patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>1.2</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% (‘lower risk’ patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>1.1</td>
<td>Within expected limits</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

The ICNACR results for the critical care unit was within expected limits compared to comparable trusts.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further.

Managers carried out a comprehensive audit programme. We saw up to date audits, for example an IPC audit and a clinical audit included a ventilator audit looking at volume being ventilated. The service also completed controlled drug audits, one found that several missing dates were not on the endorsement for amendments, the audit documented these require two signatures, an explanation and the date the amendment was made.

Managers used information from the audits to improve care and treatment. Managers at a local level had a good oversight of the ICNARC data and told us they had a delay of getting patients onto the unit, they recorded transfers and kept weekly reports to monitor this, which fed into the Mid Trent Critical Care Network.

Managers shared and made sure staff understood information from the audits. Outcomes of audits were discussed at the monthly clinical governance meetings and bi-monthly at the trust-wide
delivery group meetings. Managers displayed audit outcomes for staff and visitors in the unit to raise awareness for ways staff could improve patient outcomes. ICNARC data was displayed on notice boards and highlighted achieved participation.

Outcomes of audits were benchmarked against other healthcare providers. For example, the Intensive Care National Audit Research Centre (ICNARC) compared results for high risk admissions from the ward, unit-acquired infections in blood and out-of-hours discharges to the ward.

Improvement was checked and monitored. The service had an ICNARC clerk available three days a week. The ICNARC clerk collated data, which was overseen by the clinical lead who was also the Mid Trent network lead. The network lead therefore fed the data into the Mid Trent critical care network.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work.

**Trust level**

From April 2018 to February 2019, 75.7% of staff within critical care department at the trust received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>14</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>12</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>80</td>
</tr>
</tbody>
</table>

**Lincoln County Hospital**

From April 2018 to February 2019, 68.4% of staff within critical care department at Lincoln County Hospital received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>8</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>6</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>38</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
At the time of our inspection the clinical educator told some staff had received their appraisal between February 2019 and the inspection and so were not reflected in the figures. However, the appraisal figure for the service at the time of the inspection was still below the trust target of 95% at 67% across the staff groups.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff we spoke with stated they felt they had the right skills and knowledge to fulfil their role. The service had link nurses for specialised areas including dementia, learning disability and safeguarding. The service demonstrated effective multidisciplinary working, this ensured consistency in meeting the needs of patients. Staff had completed intermediate life support training, an essential skill in critical care services.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with told us they received relevant training as part of their four-week induction. Supernumerary including newly qualified staff also received four weeks supervised support and training from a band 6 mentor. The trust had a preceptorship course for newly qualified staff.

There were enough clinical educators to support staff learning and development. The service had a band 7 clinical educator, who provided support for staff as and when required. The clinical educator also provided on the job learning through bedside support for staff. Staff we spoke with felt very supported by the clinical educator, however there was no documented band 6 support in education.

The clinical educator together with the Advanced Critical Care Practitioner (ACCP) were developing a simulation unit on the critical care unit for chest drains, airway management and sepsis.

The ACCP was complimented continuously during our inspection for their work on the critical care unit. There was only one role for the ACCP in the Mid Trent Critical Care Network, the position was being piloted for 12 months from December 18 to December 19, with a business case put forward to make the position permanent. The ACCP worked four days a week 8am to 6pm, with a vision of 24 hours a day seven days a week. The ACCP had a Faculty of Intensive Care Medicines (FICM) membership and was in comparison to a middle grade doctor.

The ACCP helped implement the long-term ward round, which included any patient on ICU for 14 or more days, and ensured twice weekly multidisciplinary input. The ACCP was included in the implementation of an electronic system going forward. The ACCP’s involvement in LocSSIPs for central venous line care, nasogastric intubation, bronchoscopy, percutaneous tracheostomy insertion intubation and chest drawn insertion had improved the service.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Staff were encouraged to attend team meetings when they were not required on the unit. Staff told us they were sent any important information, feedback or shared learning by email when they could not attend a staff meeting.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Band 6 staff and above received advanced life support training, however managers were aware only 14/16 members of staff had completed it due to staff leaving. The clinical educator told us band 6 mentors were aware of where staff were at in completing the national competency framework. Managers provided support in increasing their skill to complete the framework. One member of staff told us staff went through processes with them to ensure they understood.
Staff told us they were provided with protected time to complete training, the clinical educator stated staff organised their own eLearning training, and the service had 92% compliance with eLearning modules.

Staff we spoke with told us they often were moved from the unit to support on understaffed wards. All staff recognised the importance of patient safety as a priority, however they felt this was impacting on their learning and development within the critical care speciality. The process of being moved detailed staff would return if required for a level three patient, one staff told us they did not return to the unit for two hours, therefore this impacted on the care within the critical care unit. Records were kept of staff movement; 35 staff moves were calculated from June 3 - June 19.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. One member of staff stated they felt upskilled by supporting student nurses as a mentor. Staff also received training they identified through the follow up clinic, for example, further training to appropriately support patients with suicidal thoughts was provided to staff through the mid Trent critical care network. The training provided was a psychology course, which included listening advice, coping strategies and sleep hygiene.

Managers were aware of the low morale among staff when they were moved from the critical care unit to support elsewhere in the hospital.

The mid Trent critical care network provided a one-day transfer trolley training course, once completed staff could transfer patients. The network also provided peer support for staff across sites.

Managers made sure staff received any specialist training for their role. However, the service was below the Core Standards for Intensive Care Units minimum requirement of 50% completion for the post registration critical care module. The figure was 41% completion. The service planned to meet this requirement by September 19, as they had five spaces on the required course for staff to fill. One member of staff told us they could not wait to enrol on the course. Staff completed a national competency framework, comprising of three steps. Once staff had completed step one, they could apply to complete the post registration critical care module.

The clinical educator told us the critical care cause included an induction booklet for staff, and competencies to achieve in the eight-week module. A workbook was completed by staff on competencies from training topics including basic critical care, respiratory including blood gases, IV (Intravenous) drugs, central lines, infusion control devices and glucose monitoring. The workbooks were marked by the clinical educator, we reviewed three workbooks and they were all completed thoroughly and were very detailed.

The CCOT (Critical Care Outreach Team) delivered a 24-hour service seven days a week from a team of nine practitioners. Six out of the nine were non-medical prescribers with two due to complete the course. The team completed 100% of their competencies and received clinical supervision from a clinical lead within their team. Staff attend bi-monthly meetings and referred to intensivists when required for further support. CCOT followed the national standard to complete ICU follow up within 24 hours. They also shared ownership with a band six nurse for the ICU follow up clinic.

The critical care outreach team also developed tracheostomy work which included a policy, a standard operating procedure, training and external agencies.

The CCOT produced audits on HIT, CCOT, AIRVO, tracheostomy, A and E and Fluid balance, and provided training for ward staff. The training included a rolling programme four days a week at 14:30 for 30 minutes. Topics included NEWS (National Early Warning Score) 2 (and Sepsis)
SBAR (Situation, Background, Assessment, Recommendation), managing deteriorating patients and fluid balance.

Physiotherapists had critical care specific training and critical care competencies they had to achieve.

Managers identified poor staff performance promptly and supported staff to improve. Managers followed trust procedures for staff performance management. Procedures were also in place for managers to encourage staff to improve. A ward manager explained that verbal feedback was given to staff regularly by managers during daily ward assurance checks. One member of staff told us they were shown step by step, when they did something wrong, they felt they were supported to do it correctly.

**Multidisciplinary working**

*Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.*

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The unit held daily ‘safety huddle’ meetings which included all relevant staff from health care disciplines. The meetings provided staff with updates on patients, including any concerns, risks or patient improvements. The multidisciplinary handover meeting also included staff from different areas, working together to share information to ensure continuity of care was received.

The service demonstrated effective multidisciplinary working, there was no hierarchical structure as all staff showed mutual respect to each other. For example, medical and nurse staff would communicate and learn from each other during updates on patients and during ‘safety huddles’. A band 7 nurse informed us the house keepers were part of facilities but recognised as part of the team on the critical care unit. We observed how effectively the service worked together to benefit patients.

Both nursing and medical staff reported they had ‘excellent relationships’ with each other. Nursing staff also demonstrated their comfortable approach to consultants and registrars. The Advanced Critical Care Practitioner (ACCP) had positive relationships with all staff across the unit, supporting staff with care for patients. Staff spoke very highly of the ACCP, and clear multidisciplinary working was demonstrated as a result.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff received support from CCOT and the trust’s mental health liaison service to provide good care for patients. Pharmacists referred patients to dietetics when required. Medical and nursing staff also worked closely with the Specialist Nurse Organ Donation (SNOD). The SNOD was the clinical lead for organ donation based on the unit and provided support to families and staff when required.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff we spoke with informed us they made a referral to the trust mental health liaison service and the crisis team out of core hours. Staff explained sometimes patients waited several hours for a mental health assessment, as patients were prioritised in Emergency Department (ED).

**Seven-day services**

*Most key services were available seven days a week to support timely patient care.*
Staff on wards could call for support from the critical care outreach team seven days a week. The critical care outreach team consisted of nine practitioners who delivered services with two staff during the day and one member of staff overnight, 24 hours a day seven days a week. The team provided support to identify and manage deteriorating or critically unwell patients.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. The service demonstrated effective consultant involvement in ward rounds which included discussions of treatment plans. There were eight consultants in total with two on call during the day and one during the night.

The service did not provide therapist cover including dietetics, physiotherapists or speech and language therapists seven days a week, however staff could refer to services as and when required.

The pharmacist was only available two days a week, this was not in line with GPIC standards of cover for five days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the unit. Notice boards around the unit provided information including advice and guidance on substance misuse and smoking cessation. Staff also provided patients and those close to them with information about smoking cessation and supported patients who wished to stop smoking.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw staff encouraged patient health promotion and had discussions with them about their needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The clinical educator organised mandatory training for staff on mental capacity, this enabled them with skills and knowledge to assess patient capacity. Staff completed mental capacity assessments and carried out best interest test where patients lacked capacity. ReSPECT forms were summaries of decisions made about individuals future care and treatment in case of an emergency. We saw correct completion of ReSPECT forms in patient notes, with personalised recommendations for a person's clinical care in a future emergency when they are unable to make decisions.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff appropriately asked patients before administering pain relief medication and documented this in their patient record.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. The service had developed a best interest care plan for level two and level three patients. The care plan included lacking capacity, best interest checklist and plan of care, which staff told us was individualised to the patients’ preferences. We
reviewed patient records with appropriate completion of best interest care plans, which included, for example, maintaining the patient’s airway, hemofiltration, chemical sedation and medicines.

The service had processes for the prevention, identification and reduction of delirium. We saw staff had carried out delirium assessments for patients, at least twice daily, using the confusion assessment method for the intensive care unit (CAM-ICU). The unit displayed on noticeboards information about delirium recognition for staff, and support for patients and relatives. Staff we spoke with were knowledgeable about delirium.

Staff made sure patients consented to treatment based on all the information available. Staff explained to patients why they received pain relief and other medication, this ensured patients understood their treatment before consenting.

Staff clearly recorded consent in the patients’ records.

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

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The MCA training delivered covers all levels required and DoLS training is included in the same session so is not reported separately.

Compliance for the MCA/DoLS training course as of February 2019 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Mental capacity act</td>
<td>97</td>
<td>116</td>
<td>83.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care the target was not met for the MCA/DoLS training module for which qualified nursing staff were eligible.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the Trust’s target.

Compliance for the MCA/DoLS training course at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Mental capacity act</td>
<td>11</td>
<td>14</td>
<td>78.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care the target was not met for the MCA/DoLS training module for which medical staff were eligible.

**Lincoln County Hospital**

Compliance for the MCA/DoLS training course for qualified nursing staff in critical care at Lincoln County Hospital is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Mental capacity act</td>
<td>57</td>
<td>64</td>
</tr>
</tbody>
</table>

In critical care at Lincoln Court Hospital the target was not met for the MCA/DoLS training module for which qualified nursing staff were eligible, although the completion rate was only just under the target.

Compliance for the MCA/DoLS training course for medical staff in critical care at Lincoln Court Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Mental capacity act</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

In critical care the target was not met for the MCA/DoLS training module for which medical staff were eligible at Lincoln County Hospital. However, the completion rate should be interpreted with care as the low number of staff will have impacted on the rate. The module needed one more staff member trained to have a 100% completion rate.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The service had a mental health lead to provide support for staff as and when they needed it.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Displays on a notice board showed details of how Deprivation of Liberty Safeguards care plan completion had improved.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with explained mental capacity assessment and how to apply the Deprivation of Liberty Safeguards.

Staff implemented DoL safeguards in line with approved documentation. Staff used a deprivation of liberty safeguards scoping tool as part of their developed level two and three patients best interest care plan.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. For example, we observed medical and nursing staff positively greeted patients and engaged in conversation with them about their wellbeing as they moved around the unit. We also saw a ward clerk taking time out to ask a patient how they were and what they had eaten for lunch that day.
We saw staff respecting patient privacy and dignity when carrying out intimate care. For example, staff drew bed curtains appropriately when required.

Patients said staff treated them well and with kindness. We observed all staff to have a positive relationship with patients. All patients we spoke with were complimentary of the care they received, stating it was 'excellent', one patient told us 'the care was out of this world'. Patients told us staff went above and beyond to care for them, and they felt staff could not do anymore for them. One patient stated the unit did not feel like a hospital, it felt like a friendship.

Staff followed policy to keep patient care and treatment confidential. We saw staff provided patient updates to one another away from other patients to ensure patient confidentiality. Staff also spoke with patients and those close to them appropriately ensuring others could not hear, for example staff offered to have discussions with relatives in the relatives’ room.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. For example, staff told us once they made a referral to mental health services, they sat and waited with patients to ensure they did not feel alone. Staff told us about a patient with mental health needs, who did not want their parents involved in their care. Staff respected the needs of the patient and sensitively requested the parents to stay in the relatives’ room.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw staff took time to care for a patient with a hearing loss. Staff rephrased questions to ensure the patient had understood. The patient told us they were grateful staff were patient with their need. One member of staff told us they respected a patient’s religious need by enabling their relatives to pray in the relatives’ room so they were close to their family member.

**Emotional support**

*Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.*

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff appropriately reassure patients and families when they were upset. For example, a nurse comforted two relatives when they saw the condition of their family member on the unit. The nurse asked the patient to squeeze their hand if they could hear them. The two relatives became further emotional as they gratefully thanked the nurse when they saw their close one’s hand move. The nurse supported the relatives and moved away at an appropriate time.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff responded quickly and reassured patients when they became distressed, staff closed the bay curtains to respect the privacy and dignity of patients. The service had quiet rooms which were offered to family members to discuss sensitive issues in privacy. We saw a Doctor appropriately suggest to update relatives of the condition of their loved one in the relatives’ room, away from the bay.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us they regularly interacted with the trust’s palliative (end of life care) team, who provided support and advice during bereavement. Staff also contacted the chaplain for advice and guidance on supporting patients and families with cultural and religious needs. Chaplaincy services were available for all patients, relatives, carers and staff. The chaplains were available on site six days a week from 9am to 5pm, excluding Saturday. Outside of core hours,
two chaplains were available on-call. Staff told us a chaplain came onto the unit regularly to support staff when required.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff provided advice and information for patients to find other support services. The service also provided a booklet for every patient and/or their relatives, which included information on emotional support services for critical care patients.

Staff attended link nurse study days which provided them with training to support patient families in discussions on organ donations. The service also provided an annual memorial service for families of organ donors.

The service provided bereavement support for family members by operating the trust’s Swan Scheme. This included bespoke education for all staff and Swan boxes containing resources to support enhanced care, such as memory bags for families and bespoke comfort packs for children. Bereavement support was available 24-hours a day seven days a week. Access to specialist nurses were available to provide emotional support for patients and families. We also saw a poster for bereavement booklets available for staff to provide to relatives. The booklet included useful counselling tools, current information for relatives and valuable contact details for further support.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients and relatives we spoke with confirmed staff explained things in a way they understood. We also saw staff following relative insight and guidance. For example, we saw relatives informing staff that their family member enjoyed listening to music. The member of staff encouraged the relatives to play a song for the patient, from their smart phone device, whilst staff informed them the patient could most likely hear the music.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff used spell boards, and boards with actions on for example, feeling tired or in pain to understand patient need. Patients pointed to the action or letters to spell words to communicate with staff. The service also used electronic boards, which enabled staff to clear the screen once used. We saw staff provided care and explained what was happening to patients and their relatives when patients were unconscious or sedated.

Staff supported patients to make advanced decisions about their care. Staff we spoke with stated they encouraged patients to make decisions about their care where possible, and supported patients in this process. We spoke with relatives of patients using the service who explained they felt involved in their relatives care and treatment, including any decisions made.

Staff supported patients to make informed decisions about their care. Correct information in the correct format was provided to patients to enable them to make decisions about their care.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. The notice board on the unit highlighted that 100% of patients during May 2019 would recommend the service.

The feedback from the Friends and Family Test was positive for the unit. The service collated this data at their patient experience event. A staff member told us staff received flowers and other gifts from patients as a thanks for the care they received.
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. There was a good oversight of critical care activity across the region with one of the consultants taking a leading role in the EMCCN (East Midlands Critical Care Network).

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service operated a single sex protocol for patients, comprising of two separate bays, one area females and one area for males, with six side rooms. The service could consistently achieve single-sex accommodation for patients. Staff told us they sometimes had mixed sex level two and three patients together, however they were only in breach if they had mixed sex level one patients.

Facilities and premises were appropriate for the services being delivered. There were side rooms available for vulnerable patients including patients with mental health concerns, learning disabilities and dementia. At times of increased demand, the service had an additional four beds to support the influx of patients. Arrangements were in place to support families to stay over nearby. The unit had two separate rooms each with a pull-out sofa bed in to allow families to stay close the their loved one. Details of arrangements for family members to stay over were available in the Intensive care unit information for patients and their family booklet. Staff told us the main reception also had details of local hotels if longer stays were required.

The service had water coolers on the unit but did not have any other food or drink available for relatives. There was a canteen available in the hospital and vending machines during out of hours. Staff told us they provided cups of tea and coffee for relatives during emotional and difficult times, which staff provided for them in the relatives’ room.

The service provided care packs for children of patients who received palliative care.

The service provided a thorough follow up clinic, led by a band 6 nurse one day a month, and the critical care outreach day one day a month, who identified patients most likely to be at risk. Patients included those at level three for 10 days or more, those who showed signs of delirium, those most likely to suffer from Post-Traumatic Stress Disorder (PTSD), post-partum admission for risk of post-natal depression. The unit contacted patients 6 weeks after discharge, and from those 10% were identified as needing further face-to-face contact. Further support was identified from areas including disturbed sleeping pattern, flashbacks, eating concerns and issues with returning to work. The follow up clinic provided one-to-one visits as required and family members were invited to support if agreed by the follow up patient.

Follow up patients could return to the unit if appropriate. Whilst on the unit, to help follow up patients remember, where appropriate, staff told us they put the alarm noise on to help encourage people’s memories. Valuable support was provided to follow up patients, as the service helped them come to terms their individual situation. Staff told us about an example of the support the follow up clinic had provided to a previous patient who presented with suicidal thoughts at their follow up phone call. Staff told us by the third visit onto the unit they had made great improvement in their health and well-being.
The follow up clinic provided patient events every six months, where a random sample of patients were invited back to the unit. This provided follow up patients the opportunity to discuss any concerns and support they required following their discharge. Staff told us the patient events also provided follow up patients the opportunity to move on from their time on the ICU. For example, one patient had been physical violent to a member of staff due to ICU delirium. The follow patient returned to the unit for the patient event and apologised to the member of staff and stated they felt horrible about the incident. The patient moved on, once they spoke with the member of staff and realised it was OK.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff could contact the trust mental health liaison service and the crisis team out of hours, however when making a referral, staff told us patients could be waiting for longer than one hour to be seen and did not always receive an assessment in a timely manner, as patients in the emergency department were prioritised for a mental health assessment.

The service had systems to help care for patients in need of additional support or specialist intervention. The service used enhanced care plans to support patients with a learning disability or a mental health concern, whilst receiving advice and guidance from trust services, for example the mental health liaison service or the palliative care team. The unit referred patients to specialist services where required, for example, therapies including Speech and Language Therapy (SALT), and dietetics. Staff worked with other health and social care providers to meet the needs of patients, including hospices and General Practitioners (GPs) to gain patient history and share patient information.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us about a patient with a mental health condition who had been referred to a specialist unit following discharge from ICU. The specialist unit did not have an available bed for two days. Staff provided extra support from the mental health liaison team and completed an enhanced care bundle for the patient before they were transferred to the specialist unit.

Wards were designed to meet the needs of patients living with dementia. Side rooms were available to support vulnerable patients. The unit had a larger clock to enable patients living with dementia a clearer view. Distraction aids including ‘Twiddle muffs’ were designed for simple stimulation activity.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Staff we spoke with told us about using the ‘This is me’ documents which followed patient pathways. Staff had access to ‘This is me’ documentation for those patients living with a Learning Disability or dementia. However, at the time of this inspection there were no patients who required this documentation.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We saw staff supported a patient with a hearing loss. Staff rephrased words and spoke at a louder volume to ensure the patient understood them. Staff met the patient’s communication needs well, and consistently confirmed what they had interpreted.
The service did not have information leaflets available in languages spoken by the patients and local community. However, staff told us they could access language line when required. Menus were also available in several languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff informed us they had good access to interpreters when required. However, at the time of our inspection, there was no need for support from interpreters or signers.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The menus offered a variety of choices to meet patient preference. Patients we spoke with confirmed they were offered a choice of food and drink.

Staff had access to communication aids to help patients become partners in their care and treatment. For example, word and sentence boards were used to support patients in communicating their needs to staff.

**Access and flow**

**People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.**

**Bed occupancy**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

From March 2018 to February 2019, United Lincolnshire Hospitals NHS Trust’s adult bed occupancy fluctuated around the England average. The rates at the trust were generally lower than or similar to the England average.

**Adult critical care bed occupancy rates, United Lincolnshire Hospitals NHS Trust**

![Graph showing adult critical care bed occupancy rates]

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

Managers worked to keep the number of cancellations to a minimum. Staff told us care and treatment was only cancelled when necessary, and delays or cancellations were explained to people, whilst supporting them to access care and treatment as soon as possible. Staff stated that patients with the most urgent needs had their care and treatment prioritised, for example a level 3 patient. The service had not cancelled operations since before April 2019, and they recognised an improvement in the number of cancelled operations.

Managers monitored that patient moves between wards/services were kept to a minimum. The unit operated an overnight transfer protocol, which meant patient transfer from critical care areas
to the general ward between 10pm and 7am was avoided whenever possible. However sometimes it could not be helped. Staff told us they reported this on their incident reporting system. Managers confirmed this only occurred twice in the last 12 months, and they kept record of out of hour discharges.

Managers and staff worked to make sure that they started discharge planning as early as possible. Patients also reported they were involved in decisions around their discharge planning. Consultants also reviewed patients within 12 hours of admission to Intensive Care, to identify the medical condition of the patient, and initiate a care plan. We saw one patient record documented a review by the ICU consultant in the Emergency Department.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff received support from the trust’s mental health liaison service and the trust safeguarding lead to ensure appropriate discharge of patients with additional needs. The unit also developed enhanced care plans, to provide detailed individualised support for those who required. The plans included input from a range of specialist services to best support the patient and prepare them for their discharge. Staff told us they also planned discharges to suit patient needs as best they could, for example ensuring relatives were there to help support the patient.

Managers monitored the number of delayed discharges and took action to prevent them. The service had use of the Hatton Ward to move patients to in an action to manage delayed discharges.

Staff supported patients when they were referred or transferred between services. The critical care outreach team had oversight of patients being transferred and shared this with staff to ensure patients were supported through their patient journey consistently. For example, we saw staff explained clearly to a patient that they were being transferred. The nurse discussed this with the patient and made sure they completely understood where they were going.

Managers monitored patient transfers and followed national standards. Patients were not transferred to other Intensive Care Units for non-clinical reasons. On day three of our inspection the unit held 16 patients, managers told us they monitored the patient levels, and if more patients at level three were transferred onto the unit they would have to review the patients with the consultant. Managers told us they discussed bed numbers with the site duty manager to see if they could step any patients down. Staff on the unit recognised the importance of not causing any delays in the emergency department.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with informed us they had no intention to make a complaint or raise a concern, they would feel confident to do this if required. Patients raised concerns which resulted in improvements to the service, for example staff reduced the level of noise on the unit by replacing bins with soft closing bin lids, after concerns were raised regarding the loudness of the bin lids constantly opening and closing. Patients and those close to them were treated with compassion and given support to raise any concerns.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We spoke with two patients who stated they felt confident to provide feedback on the service. We also asked if they knew how to make a complaint, both confirmed
they did, however they had nothing to complain about. Booklets provided to every patient and relative included information on how to make a complaint through the Patient Advice and Liaison Service (PALS).

The service clearly displayed information about how to raise a concern in patient areas. There were boards displayed encouraging patients or relatives to raise concerns to staff. Details on making a referral to PALS was also provided to every patient or relative on the unit in their critical care information booklet. Information on the patient event held as part of the follow up clinic was displayed on a noticeboard in the unit. Information also included improvements made from complaints received, titled ‘you said, we listened’. For example, relatives felt they were left for periods of time when using the relative room for privacy. Following this complaint, the unit had installed cameras in the relative room which ensured staff could monitor who was in the relatives’ room.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with demonstrated the policy they would follow to handle complaints appropriately. Staff had no examples of handling complaints, as they had not directly received any. However, staff were aware of how to appropriately handle complaints if required. The service also displayed six pledges on a notice board, one included dignity in care for patients and carers when making a complaint. This ensured people who raised concerns or complaints were protected from discrimination, harassment or any disadvantage.

Managers investigated complaints and identified themes. There was one complaint made at the time of our inspection. The ward leader investigated the complaint and provided a timely response to the complainant with an apology and findings from the investigation. The complaint was handled in a way which ensured openness and transparency, whilst respecting patient confidentiality.

**Summary of complaints**

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service had one complaint from March 2018 to the time of our inspection. The ward lead informed us of the appropriate process they took following the complaint including investigating the concerns and provided timely feedback to the complainant. The feedback included an appropriate apology.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with told us they received emails informing them of complaints and lessons learned were shared.

**Trust level**

From March 2018 to February 2019 the trust received three complaints in relation to critical care (0.4% of total complaints received by the trust).

The trust took an average of 44 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 35 working days, or 50 working days for more complex complaints. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Care &amp; treatment</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Values and behaviour</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Both Lincoln County hospital and Pilgrim hospital had one complaint each, with the third relating
to Grantham hospital.

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

**Number of compliments made to the trust**

From March 2018 to February 2019, there were 398 compliments about critical care at the trust. A breakdown of compliments by site is below

<table>
<thead>
<tr>
<th>Site name</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of compliments</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>290</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>108</td>
</tr>
<tr>
<td>Total</td>
<td>398</td>
</tr>
</tbody>
</table>

Both sites just had the one department which received compliments. These are detailed above.

The trust noted that, alongside the compliments received by wards and services, there were an additional 746 comments recorded trust-wide. These were comments from patients, families and staff directly to the services and staff with whom they came in contact.

A theme from the compliments received trust-wide was good communication.

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

During our inspection, patients and relatives we spoke with consistently complimented the service and the staff caring for them.

**Is the service well-led?**

**Leadership**

Most leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Most were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust had a new Trust Operating Model (TOM), which meant leadership for the critical care unit was under the divisional leads for Surgery including the Divisional Clinical Director, Divisional Managing Director and the Divisional Nurse. The Theatres, Anaesthetics and Critical Care (TACC) team followed which included the lead Nurse, Clinical Service Manager and the Clinical Lead for critical care. The Matron lead the service at a local level followed by the unit manager and clinical nurse educator.

We found leaders at a local level, including Band 7 and 8a, had good oversight of the service, and understood the challenges to quality and sustainability and they identified actions needed to address them. Managers stated within critical care there was a clear line nursing hierarchy. All staff confirmed they were visible and very approachable. Staff we spoke with stated the Matron was visible even though they worked across site and attended the multidisciplinary handover meeting when they were based at Lincoln County critical care unit.

However, the service had a new middle management team coupled with a new divisional team structure which meant that oversight of critical care at this level was not currently robust. For example, the senior management team had a limited oversight of where GPIC standards were not
met, for example therapists and pharmacy cover. Staff we spoke with were not aware of who the new leadership team were, although they were aware that changes to staff at that level had occurred.

At a local level there were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. Managers had plans in place to manage critical care patients from Pilgrim Hospital, as there was an increased risk of flooding on the unit a week before our inspection. Managers had effectively informed staff as they were aware of the contingency plan.

The matron told us of the service planned to rotate nursing staff across to the pilgrim site and rotate the staff at Pilgrim to the Lincoln site. The matron stated this was a good career progression for staff a positive opportunity for cross site teamwork. A positive response had been received from staff.

The service had a mental health lead who offered appropriate expertise in mental health support, for staff, patients and relatives. Referrals were made to the trust’s mental health liaison service to ensure further support was provided for patients with mental health conditions.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The Trust had dignity in care pledges, including, “to be kind and compassionate at all times, to treat you with courtesy, dignity and respect, to respect your personal space, to preserve your modesty, to meet your dietary needs and to care for you as a valued individual”. The critical care unit displayed responses on a noticeboard to each pledge, which detailed how staff achieved each pledge. We saw staff achieved these pledges.

The middle management team identified the critical care strategy was to step down patients to level one appropriately and in a timely manner, and to improve patient experience. Managers recognised this aligned to local plans in the wider health and social care economy. Managers ensured services had been planned to meet the needs of relevant population.

The trust values included patient-centred care, excellence, respect, compassion and safety. We observed all staff in the critical care unit followed these values, and staff we spoke with were aware and understood the trust values.

The trust vision and strategy were inclusive of people with mental health conditions.

**Culture**

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers across the unit promoted a positive culture, and there was a strong family feel within the unit. When remaining on ICU staff felt valued and respected and were committed to delivering safe
patient-centred care to meet the needs of the people using the service. This created a sense of common purpose based on shared values between staff and managers at a local level.

However, staff did not feel valued and supported outside of the critical care unit and felt frustrated with being moved off the unit to support other areas of the hospital. Whilst all staff recognised the importance of patient safety as a priority, they felt being moved off the unit they were not learning the skills required specifically for a critical care practitioner.

Staff of all levels and roles said the service was a good place to work, with staff being either on the unit for several years or were newly qualified. A nurse told us staff could admit mistakes and raise concerns without fear of retribution. Staff told us the culture on the unit was a learning culture, to be open and honest. Staff demonstrated appropriate application of the Duty of Candour.

Staff felt well supported in their role, and there was a strong emphasis on the safety and well-being of staff. Staff told us about an emotionally challenging experience on the unit, where they were greatly supported after. Staff were offered one-to-one and group counselling, one member of staff explained how valuable the counselling service was to help them come to terms with the incident.

The unit demonstrated effective multidisciplinary working, across all levels there was a clear mutual respect and no obvious hierarchy. Nursing and medical staff had positive and supportive relationships and would share learning across the disciplines to work collaboratively, share responsibility and to resolved conflict quickly and constructively.

**Governance**

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

The unit had a newly appointed senior management team at the time of our inspection they did not appear to have a clear oversight of the governance on the critical care unit. However, the local managers had sound knowledge of governance processes.

Regular structured multidisciplinary clinical governance meetings were held to discuss unit morbidity and mortality, including all deaths, critical incidents and near misses. A written record documented actions taken and lessons learnt in a timely and reliable method for dissemination of shared learning. The critical care outreach team held bi-monthly meetings and provided monthly updates to the ICU team.

There was an effective governance framework to support the delivery of the strategy and good quality care. Monthly governance meetings were held and included a multidisciplinary staff, including consultant input. Band 6 and 7 monthly meetings were held offering support and identification of any issues to discuss.

The service had a robust system in place for reporting, investigating, and learning from all patient safety incidents, in line with guidelines for the provision of Intensive Care Services. The service also displayed updates on the unit for staff and patients.

**Management of risk, issues and performance**

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
The service had plans in place for increased demand. The matron told us they would use the remaining side rooms as they were equipped for 20 beds.

There was corporate electronic risk register in place for recording and managing risks. The risk register included a description of each risk, the owner and actions taken. Managers explained the challenges for the service and showed us the trust risk register displaying the risks. The risks included the financial restraints on the ventilator replacement programme.

Managers attended monthly clinical governance meetings to discuss incidents, safety thermometer and audits. Ward managers and sisters held monthly critical care meetings to look at staffing, finances, admissions, equipment issues and safety thermometer results. CCOT had bi-monthly meetings. Ward managers escalated any concerns to the monthly clinical governance meeting. Information was shared from leaders to enable all staff access to the records.

Consultants and staff led on internal audits such as a volume being ventilated, sedation hold, pressure ulcers and nursing health record keeping. CCOT also provided audits on HIT, AIRVO, tracheostomy and fluid balance. Pharmacy completed audits on control drug checklists.

During our inspection we discussed ICNARC data with the senior leadership team and they did not have an oversight of any actions following the outcome of data. Following the inspection, we requested an action plan relating to the results. We did not receive an action plan as requested.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

At a local level the service had a holistic understanding of performance, which sufficiently covered and integrated people’s views with information on quality, operations and finances. Information was used to measure improvement not just assurances.

Staff used paper records for patients which were kept securely, the service planned to use an electronic system along with Pilgrim Hospital critical care unit to assess patients and manage their care including administration of medicines. This was planned to be in place by the end of the financial year. The electronic system will enable the unit to better monitor and improve quality of care.

Service performance measures were reported and monitored. The matron and the ward manager had access to a quality and safety figures, which provided performance measures.

Serious incidents, incidents, the risk log, information governance, medicines, harm events and audit results were recorded appropriately at monthly governance meetings and were shared with staff.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People’s views and experiences were gathered and acted on to shape and improve the services and culture, for example managers at a local level were aware of concerns staff had regarding nursing staff being moved from the unit, they told us they were looking at supporting staff in this process to improve the culture among staff.
People who used services, those close to them and their representatives were actively engaged and involved in decision-making, as the service held patient experience events six monthly, to allow people who previously used the service and those close to them to give feedback in ways to make the service better for patient care.

The unit also operated a follow up clinic, to support those who were not managing effectively following their stay on the unit. Feedback was also provided as identified when they revisited the unit.

Staff felt actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture, within the critical care unit. However, staff did not feel their views were reflected through middle management or across the trust. Staff gave examples which included them being moved to areas across the hospital.

Leaders prioritised the participation and involvement of people who use services and staff. Leaders managed complaints effectively, appropriately investigated them and provided timely feedback. Staff told us the trust’s Director of Nursing also attended the weekly band 7 forum, to support staff with concerns.

Both leaders and staff understood the value of staff raising concerns, as this provided improvements for both staff well-being and patient experience. Appropriate action was taken as a result of concerns being raised.

**Learning, continuous improvement and innovation**

*All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.*

Leaders of the critical care service promoted staff to lead on innovative projects to promote improvement to the service to benefit patients and their families.

Staff regularly took time out to work together to resolve problems to review individual and team objectives, leading to performance and innovation. For example, displayed on a noticeboard was areas of improvement, included were patients at risk of self-harm and vulnerable patients. The critical care service had developed enhanced care plans to support vulnerable patients, patients with a mental health condition or a learning disability. Staff we spoke with were aware of the enhanced care plans and told us about completing falls risk assessments as part of the care bundle for vulnerable patients.

The service had improved the delivery of mental health services, for example, the service developed a ligature risk assessment for patients at risk of self-harm, to support patients with a mental health condition. Staff we spoke with were aware of the risk assessment report.

We saw records of best interest care plans the service developed for level two and level three patients. The care plan included lacking capacity, best interest checklist and plan of care, which staff told us was individualised to the patients’ preferences.

The ACCP demonstrated effective use of LocSSIPs to ensure staff followed best practice. The ACCP role was being piloted for 12 months, however, staff told us they received funding to make the position permanent.

The critical care unit offered a thorough follow up clinic, led jointly by a band 6 nurse and the critical care outreach team. They originally supported patients with a follow up phone call, included those at level three for 10 days or more, those who showed signs of delirium. However, they recognised a gap in those most likely to suffer from Post-Traumatic Stress Disorder (PTSD), and
post-partum admission for risk of post-natal depression. Staff felt they increased the gap in reaching those patients who most required it.

The follow up clinic also included a patient event day, where the unit invited a random sample of patients to the hospital to discuss any concerns and support they required following their discharge. The service had a positive response from this and improved their service due to feedback received.
Maternity services are located on three hospital sites: Lincoln County Hospital, Pilgrim Hospital and Grantham and District Hospital. In-patient services are delivered at both Lincoln and Pilgrim hospitals whilst outpatient services are provided at Grantham and District Hospital.

Services on all sites are run by one maternity and gynaecology management team.

(Source: Routine Provider Information Request (RPIR) – Acute sites)

The maternity service at Lincoln County Hospital included an antenatal clinic, an antenatal assessment unit, and a maternity ward. The ward (Nettleham) was used for antenatal and postnatal inpatients and consisted of 31 beds and a further six beds for use by the antenatal assessment unit and or to relieve capacity on the ward. The service provided four beds used as a transitional care area on the ward. The labour ward had ten side rooms, one of which included a birthing pool and they had access to two theatres. The rooms on the labour ward were of varying sizes and two were in use as a midwifery led environment while they awaited renovations being completed to provide an alongside midwifery led unit. There was also a dedicated bereavement room located on Nettleham ward.

Trust wide community midwife teams covered Skegness, Spalding, Grantham, Sleaford, Lincoln, Gainsborough and Boston.

The Early Pregnancy Assessment Unit (EPAU) was located within the gynaecology unit. The EPAU provided early scans and consultations for women experiencing problems in pregnancy between six and 20-week gestation.

There were 2695 births at Lincoln County Hospital between July 2018 and May 2019.

From January 2018 to December 2018 there were 4,702 deliveries at the trust.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at United Lincolnshire Hospitals NHS Trust – Comparison with other trusts in England.
A profile of all deliveries and gestation periods from January to December 2018 can be seen in the tables below. The trust had an older age profile when compared to the England averages.

### Profile of all deliveries (January to December 2018)

<table>
<thead>
<tr>
<th></th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>4,635</td>
<td>98.7%</td>
</tr>
<tr>
<td>Multiple</td>
<td>63</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Mother's age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>204</td>
<td>4.3%</td>
</tr>
<tr>
<td>20-34</td>
<td>3,759</td>
<td>80.0%</td>
</tr>
<tr>
<td>35-39</td>
<td>609</td>
<td>13.0%</td>
</tr>
<tr>
<td>40+</td>
<td>126</td>
<td>2.7%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,698</td>
<td></td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.

### Gestation periods (January to December 2018)

<table>
<thead>
<tr>
<th></th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Gestation period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>3,810</td>
<td>92.8%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Total number of deliveries with a valid gestation period recorded</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,107</td>
<td></td>
</tr>
</tbody>
</table>

United Lincolnshire Hospitals NHS Trust Post-inspection Evidence appendix
Notes: This table does not include deliveries where the delivery method is ‘other’ or ‘unrecorded’. Gestation periods were unrecorded for 12.6% of deliveries at this trust compared to 18.7% nationally.

To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with ‘***’ (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, additional numbers (generally the next smallest) have also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter from October 2016 to December 2018 can be seen in the graph below.

Number of deliveries at United Lincolnshire Hospitals NHS Trust by quarter.

(Source: Hospital Episode Statistics - HES Deliveries (January 2018 - December 2018)
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 service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

Nursing and midwifery staff received their mandatory training and were up to date on four out of 11 training modules, however service leaders told us it was an improving picture.

Their training data was collated over a 12-month period; therefore some staff were still within their timeframe of completion at the time the data was provided. They said they had also implemented incentives for compliance in training modules such as entering a raffle when fully compliant, which staff said encouraged them.

The trust set a target of 90% for completion of mandatory training, with the exceptions of:
- Fraud awareness and infection prevention level one, which had targets of 95%.
- Local fire procedures and fire safety, which had targets of 100%.
- Immediate life support (ILS)/advanced life support (ALS) and medicine management training which had no targets. The trust informed us that the eligible numbers of staff were not available for these two courses and therefore we were unable to calculate completion rates.

Please note that the trust’s medical staff work across both maternity and gynaecology.

Lincoln County Hospital maternity department

A breakdown of compliance for mandatory training courses as of February 2019 for qualified midwifery staff in maternity at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; safety</td>
<td>128</td>
<td>131</td>
<td>97.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>127</td>
<td>131</td>
<td>96.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>127</td>
<td>131</td>
<td>96.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>126</td>
<td>131</td>
<td>96.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>125</td>
<td>131</td>
<td>95.4%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>123</td>
<td>131</td>
<td>93.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>119</td>
<td>131</td>
<td>90.8%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>117</td>
<td>131</td>
<td>89.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>115</td>
<td>131</td>
<td>87.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>115</td>
<td>131</td>
<td>87.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>113</td>
<td>131</td>
<td>86.3%</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>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

In maternity the target was met for four of the 11 applicable mandatory training modules for which qualified midwifery staff at Lincoln County Hospital were eligible. The remaining module had no eligible staff number available and no completion target but had staff members who had
completed the module.

Medical staff received and were up to date with four out of 11 of their mandatory training modules, however, the completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.

A breakdown of compliance for mandatory training courses as of February 2019 at Lincoln for medical staff in maternity and gynaecology is seen below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>8</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>8</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>8</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>8</td>
</tr>
<tr>
<td>Fire safety</td>
<td>8</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>7</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>7</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>7</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>5</td>
</tr>
<tr>
<td>Information governance</td>
<td>5</td>
</tr>
<tr>
<td>Basic life support</td>
<td>4</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1</td>
</tr>
</tbody>
</table>

Across maternity and gynaecology, the target was met for four of the 11 applicable mandatory training modules for which medical staff were eligible. However, the completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.

The remaining module had no eligible staff number available and no completion target but had staff members who had completed the module.

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

The mandatory training was comprehensive and met the needs of women and staff. It took place over two days as well as Practical Obstetric Multi-Professional Training (PROMPT) for all staff. Multi-disciplinary emergency ‘skills and drills’ simulation training was completed by all midwives and obstetric staff including consultants.

Saving Babies Lives training days which included growth surveillance, fetal monitoring and neonatal resuscitation. CTG training was included in the Saving Babies Lives training day and covered during PROMPT training.

Clinical staff completed training on recognising and responding to women with mental health needs, learning, disabilities, autism and dementia. The training was through eLearning and had been a more recent addition to the mandatory training schedule.

Managers monitored mandatory training and alerted staff when they needed to update their training. All staff said they were given adequate time to complete their mandatory training and were prompted by their managers when their compliance was falling. The matron had oversight of all training compliance and met regularly with ward managers to identify individual staff who were not compliant and then identified dates for their completion of training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with
other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

**Safeguarding training completion rates**

Midwifery staff received training specific for their role on how to recognise and report abuse.

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

Please note that the trust’s medical staff work across both maternity and gynaecology.

**Lincoln County Hospital maternity department**

A breakdown of compliance for safeguarding training courses for qualified nursing staff in maternity at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>124</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>124</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>121</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>119</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>118</td>
</tr>
<tr>
<td>Safeguarding children (level 3 additional)</td>
<td>27</td>
</tr>
</tbody>
</table>

The 90% target was met for each of the six safeguarding training modules for which qualified nursing staff in maternity at Lincoln County Hospital were eligible.

Most medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of February 2019 at Lincoln County Hospital for medical staff in maternity and gynaecology is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>7</td>
</tr>
</tbody>
</table>

Across maternity and gynaecology, the 90% target was not met for any of the six safeguarding training modules for which medical staff were eligible. However, the completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.

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

Policies, procedures, protocols and frameworks relating to safeguarding were in line with national guidance and staff told us they were easily accessible.

Clinical staff working with children, young people and/or their parents received training at level 3, in line with national guidance. This training included an awareness of Child Sexual Exploitation.
(CSE), modern day slavery and female genital mutilation (FGM) and outlined responsibilities for reporting and referring cases identified. The trust had an FGM guideline to support staff with this. All staff we spoke with were aware of the policy and knew how to refer and report.

The trust did not specifically record cases of child sexual exploitation (CSE), however all cases of CSE were referred through the multi-agency safeguarding procedures.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we spoke with had good knowledge of safeguarding processes and had a specialist safeguarding midwife who supported staff across the trust should they require it. Staff had good relationships with the local safeguarding team and said they were easily accessible. Staff knew how to identify patients who were at risk and said they would refer those women to the safeguarding team. They also referred them to other appropriate professionals for extra support if required.

Our review of women’s records showed staff assessed women’s social circumstances and identified any safeguarding concern.

Staff informed us there was no specialist teenage pregnancy midwife even though they handled up to 30 cases of teenage pregnancies across the trust each month. They informed us they referred babies to social care services if there was a safeguarding concern regarding a teenage mother.

Although the safeguarding team indicated the trust could benefit from additional specialist midwives to support the migrant community, teenage pregnancy, substance misuse and domestic abuse, they stated they were able to manage the workload safely.

Staff were trained to identify potential sexual exploitation of children. Staff were able to provide examples of how they safeguard vulnerable women, including victims of adult trafficking. Where relevant staff referred such cases to the police, involved social services and liaised with relevant agencies to keep women and children safe.

A specialist mental health midwife liaised with the perinatal mental health team to safeguard women with mental health issues and their unborn child. Staff captured any previous history of mental health at the antenatal clinics and escalated it to the safeguarding team.

Staff followed safe procedures for children visiting the ward. Staff followed the baby abduction policy and carried out baby abduction drills.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. During the inspection we observed all of the clinical environment to be visibly clean and clear cleaning schedules completed daily, weekly and monthly. Cleaning records were up to date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to infection prevention and control policies, procedures and guidelines on the trust intranet. We saw staff adhered to these policies in relation to hand hygiene and infection control. For example, we saw staff did not wear watches or jewellery in line with the ‘bare below the elbow’ rule and demonstrated good hand hygiene in all clinical areas.
Staff had access to and used suitable personal protection clothing such as gloves and aprons to mitigate against infection.

There was a sufficient supply of hand sanitising gels, which were regularly checked and sinks throughout the clinical area with handwashing prompts for staff, women and visitors.

All areas had disposable curtains, we saw the curtains looked visibly clean and had dates written on them to remind staff when they needed to be replaced.

Cleaning chemicals were stored in locked cupboards so not accessible to members of the public. This was in accordance with the Control of Substances Hazardous to Health standards. Under the Control of Substances Hazardous to Health Regulations 2002, employers need to either prevent or reduce their workers' exposure to substances that are hazardous to their health.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw use of ‘I am clean’ stickers throughout the unit to identify equipment which was cleaned and ready for use, all of those labelled as clean and ready for use were visibly clean.

The service carried out hand hygiene audits every month. Results showed a consistent compliance rate of 100% for all clinical areas during the period from July 2018 to May 2019, with the exception of one result of 98% for February 2019 on Nettleham Ward.

A piece of work was undertaken by the trust between January and March 2019 (quarter four) which changed the way in which hand hygiene was assessed. Prior to this the trust would receive consistent 100% hand hygiene compliance in most areas and recognised that this probably did not reflect actual practice. The trust therefore changed the hand hygiene assessment methodology to better reflect a more accurate position and to show the areas where non-compliance needed support. During quarter four, the infection prevention and control (IPC) team briefed the trust IPC committee to advise that they expected hand hygiene numbers to decline as the new assessment tool was rolled out. This guided the IPC team on where they needed to focus their efforts to support improvements.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

All ward areas were tidy and clutter free. The labour ward had two theatres which were used predominantly for emergency procedures, however they had an elective list on Thursdays with a dedicated team and performed some elective caesarean sections throughout the week with a plan to increase the elective lists over time.

Women could reach call bells and staff responded quickly when called. Women we spoke with told us and we saw call bells were responded to in a timely manner.

The design of the environment followed national guidance. The labour ward met recommendation from the Department of Health that birthing rooms should include en-suite facilities (DH Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities, 2013).

Staff carried out daily safety checks of specialist equipment. Emergency equipment was easily accessible and checked daily in accordance with the trust’s policy. The neonatal resuscitation equipment including the resuscitaires in all areas were checked daily. Resuscitaires are used as a warming therapy platform with facilities for managing a clinical emergency.

The service had suitable facilities to meet the needs of patient’s families. The labour ward had one birthing pools which was clean and well maintained, and there were evacuation procedures in place to remove a woman from the pool in an emergency. Staff we spoke with knew the pool-
cleaning regime and staff had training to use the nets available for pool evacuation. There was no midwifery led unit provided by the trust, however there were major works due to be carried out which included an alongside midwifery led unit. In the interim period the ward provided two delivery rooms on the labour ward which were used to care for women assessed as low risk and chose midwifery led care. The rooms were adapted to appear less clinical by the bed being situated against the wall, medical equipment kept out of sight, additional aids such as birthing balls etc. Staff told us if a women was assessed as higher risk as her labour progressed, she would remain in the room and the equipment and medical staff would be brought to her.

There was a dedicated bereavement room to support bereaved families, which consisted of a double bedded room with furnishings for a homely feel.

Four beds were provided as a transitional care area on Nettleham Ward, women were cared for by the midwives and babies were cared for by the neonatal team.

The service had enough suitable equipment to help them to safely care for women and babies. Cardiotocography (CTG) machines were available for women who required continuous electronic fetal heart monitoring. A CTG machine is used to record both the baby’s heart rate and uterine contractions during pregnancy and labour. Its purpose is to monitor the baby’s wellbeing and allow early detection of distress.

Equipment available in an emergency included sepsis boxes, anaphylaxis boxes, cardiac arrest boxes and hypoglycaemia boxes. There were resuscitation trolleys and trollies containing emergency equipment in the event of an antepartum haemorrhage, post-partum haemorrhage, cord prolapse and pre-eclampsia.

Staff completed temperature checks daily for the fridges in all areas and reported any faults. All electrical equipment we reviewed was appropriately maintained. None of the items were overdue for service and all had a visible safety tested sticker demonstrating when the equipment was next due for service.

An intercom and buzzer system was used to gain entry to each of the maternity wards and the delivery suite to identify visitors and staff so that women and their babies were kept safe. The exits were also controlled in those areas.

Staff disposed of clinical waste safely. Suitable arrangements were in place for the management of clinical specimens and waste disposal. Clinical waste bins were emptied regularly and contaminated sharps were segregated according to their nature. All oxygen bottles were stored securely and appropriately.

Assessing and responding to patient risk

**Staff completed and updated risk assessments for each women and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Midwifery staff used an early warning assessment tool known as the modified obstetric early warning score (MEWS) to assess the health and wellbeing of all inpatients. This assessment tool enabled staff to identify and respond to a woman whose health was deteriorating and summon additional medical support if required.

Baby’s observations were documented on a new-born early warning score track and trigger chart (NEWS). Pulse oximetry was performed on all new-born babies (to measure the oxygen levels) which helped identify babies whose heart and lungs were less healthy.
Staff completed risk assessments for each women on admission / arrival and updated them when necessary and used recognised tools. During the initial booking appointment, community midwives took a comprehensive medical, obstetric and family history from women. The booking record was kept in the hand-held records and an electronic copy was created. Copies of any ultrasound scan reports and results of any blood tests were kept as part of the hand-held record. As part of the initial booking, midwives made assessments of women’s social situation, tobacco, drug and alcohol use and carried out a mental health assessment.

The service provided antenatal services, women could be referred by community midwives, GPs, A&E or women could self-refer. All women who might be in labour, had pain or were bleeding or felt reduced fetal movements were initially referred to the service, including women who required additional monitoring of their baby or review of women with other conditions such as raised blood pressure.

Induction of labour (IOL) was offered at Lincoln County Hospital on the Labour Ward. We were told delaying IOL was part of the escalation pathway. A clinician prioritised which inductions were safe to delay and which were not.

Obstetric theatres used a modified version of the World Health Organisation (WHO) ‘Five Steps to Safer Surgery’ safety checklist prior to and during each procedure, which we observed. This is a process recommended by the National Patient Safety Agency (NPSA) for every woman undergoing a surgical procedure. The process involves several safety checks before, during and after surgery to avoid errors. For each woman’s procedure, we were told the checklists were followed and completed in full. We saw the initial stages of the WHO safety checklist were completed correctly and were recorded on an electronic record. In the event of an emergency procedure, staff told us sufficient checks would be carried out to proceed without compromising the safety of the woman or baby by delaying the start of the procedure.

Audit data was provided by the trust following the inspection in relation to WHO checklist compliance in theatres at Lincoln County Hospital during a five month period between 1st January and 31st May 2019. The audit showed 100% compliance.

There were blood gas analysers on the Labour Ward, in line with national recommendations. This meant staff could quickly analyse blood products from both women and babies to assist with planning care.

Staff knew about and dealt with any specific risk issues. Staff assessed patients upon admission to the antenatal service to identify women who had extra needs. We saw assessments of venous thromboembolism and of immunisation history were also recorded. Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein. This is most common in a leg vein, where it is known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE). We formally requested data from the trust relating to antenatal key performance indicators, however the trust did not provide this.

These assessments, together with the medical and obstetric history, were used to classify women as ‘low’ or ‘high’ risk. Low risk women had the option of midwifery-led care, whilst high risk women were referred to consultant-led care. However, there was a guideline in preparation to offer care which was provided in the midwifery led setting to certain women who were assessed as ‘high risk’ with an oversight from a consultant.

At each antenatal contact women’s individual risks were reviewed and reassessed. Only women risk assessed as low risk could usually plan to give birth within their own home.
The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman’s mental health. The specialist perinatal mental health midwife was easily accessible and crisis team could be contacted for advice.

Shift changes and handovers included all necessary key information to keep women and babies safe. Staff shared key information to keep women safe when handing over their care to others. We saw staff used electronic methods for recording the handover of women’s care. We observed their use of the Situation, Background, Assessment and Recommendation (SBAR) forms for handover when women were moved from any of the wards, Labour Ward and after a shift change. SBAR is a technique which can be used to facilitate and prompt appropriate communication especially amongst healthcare professionals. SBAR stickers were used in the paper records or recorded in the electronic version, and in both versions, both staff members were required to sign or acknowledge the handover.

**Midwifery Staffing**

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough midwifery staff of all grades to keep women safe. There were sufficient staffing levels during our inspection. The postnatal and antenatal inpatient ward was staffed as planned as was the labour ward throughout our inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. In accordance with national guidance. Staffing levels were planned and reviewed to ensure women and babies received safe care and treatment.

The service used the National BirthRate Plus acuity tool. In 2016, the maternity service used the National BirthRate Plus acuity tool to calculate midwifery staffing levels, in line with guidance from the National institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015. (Birth-rate plus is a tool used to calculate midwifery staffing levels, based on the ward activity and needs of the women. Acuity is the measurement of the intensity of nursing care required by a patient). The trust report was completed in 2017, an updated BirthRate Plus tool was planned to be implemented for labour ward and Nettleham ward following a period of training.

Staffing levels were displayed in all the clinical areas we visited and we saw information displayed indicated actual staffing levels met planned staffing levels.

Community caseloads we one midwife to 70 women and due to be reviewed.

The service utilised the NICE ‘red flag’ system that alerted when patient safety was compromised due to staffing issues for example delay in suturing or not achieving one to one care in labour.

The ratio recommended by ‘Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour’ (Royal College of Midwives 2007), based on the expected national birth rate, was one whole time equivalent (WTE) midwife to 28 births. Pilgrim Hospital maternity midwife to birth ratio was better than the recommended standard. The ratio of midwives was one to 25 women.

Staffing levels were displayed on each of the ward areas and labour ward and during the inspection we saw expected staff levels were mostly in line with actual staffing numbers. We were told there were always two experienced band 7 midwives on every shift, one acted as the labour
ward coordinator who was usually supernumerary and the other provided cover for breaks, support for staff.

### Lincoln County Hospital

Lincoln County Hospital reported the following WTE the nurse and midwifery staff numbers for the periods below for maternity.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Specialist midwives</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Midwifery rotational</td>
<td>55.1</td>
<td>57.3</td>
</tr>
<tr>
<td>Nettleham Ward</td>
<td>4.2</td>
<td>6.8</td>
</tr>
<tr>
<td>Bardney Ward</td>
<td>14.7</td>
<td>14.5</td>
</tr>
<tr>
<td>Community Lincoln</td>
<td>24.1</td>
<td>23.6</td>
</tr>
<tr>
<td>Antenatal clinic</td>
<td>9.3</td>
<td>8.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>111.4</strong></td>
<td><strong>114.3</strong></td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the nurse and midwifery staffing rate within maternity at Lincoln County Hospital was 97.5%. This was lower than the rate of 99.8% in the more recent period from April 2018 to February 2019. (Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The ward manager could adjust staffing levels daily according to the needs of patients. We were told and we saw staff worked on a rotational basis and were happy to work on whichever ward where they were most required on a shift to shift basis.

Staff worked a mixture of shifts including early, late, long days and nights and the planned number of qualified staff for labour ward for each shift was 9 midwives.

The number of midwives and healthcare assistants on all shifts on each ward matched the planned numbers. There was a significant increase in staff provided on Nettleham Ward during April 2018 to February 2019 compared to a 61.8% staffing rate from April 2017 to March 2018. During our inspection, staff said they felt less pressure than the previous year.

Staffing escalation measures included cancelling some mandatory training, pulling midwives from the ward and specialist midwives or other staff rostered for non-clinical duties.

### Vacancy rates

The trust did not have an overall target vacancy rate; however Lincoln County Hospital Maternity Unit reported a 2.1% vacancy rate compared with the trust vacancy rate of 2.8% for nursing and midwifery staff in maternity.

### Trust level

From April 2018 to March 2019, the trust reported a vacancy rate of 2.8% for nursing and midwifery staff in maternity. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital maternity department: 2.1%

A breakdown of vacancy rates by ward/department for each site is below

### Lincoln County Hospital
### Ward / team name | Annual vacancy rate
--- | ---
Specialist midwives | 8.6%
Antenatal clinic | 6.7%
Community Lincoln | 5.6%
Nettleham Ward | 4.9%
Midwifery rotational | 4.4%
Bardney Ward | -18.8%

The negative figure indicates there were more WTE in post than originally planned.

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

### Turnover rates

Each ward had turnover rates above the trust target of 8% with the exception of Bardney Ward which had a turnover rate of 5.7% and below the trust target.

### Trust level

From April 2018 to March 2019, the trust reported a turnover rate of 7.2% for nursing and midwifery staff in maternity. This was lower than the trust target of 8%.

- Lincoln County Hospital maternity department: 8.9%

A breakdown of turnover rates by ward/department for each site is below

#### Lincoln County Hospital

There were five wards with turnover recorded at Lincoln from April 2018 to March 2019.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Clinic</td>
<td>17.9%</td>
</tr>
<tr>
<td>Midwifery Rotational</td>
<td>9.7%</td>
</tr>
<tr>
<td>Community Lincoln</td>
<td>8.9%</td>
</tr>
<tr>
<td>Nettleham Ward</td>
<td>8.4%</td>
</tr>
<tr>
<td>Bardney Ward</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

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

### Sickness rates

Lincoln County Hospital Maternity Unit had sickness rates above the trust target overall. However, antenatal clinic and labour ward were significantly lower and Lincoln Community Midwifery were at or below the trust target.

### Trust level

From April 2018 to March 2019, the trust reported a sickness rate of 4.5% for nursing and midwifery staff in maternity. This was the same as the trust target of 4.5%.

- Lincoln County Hospital maternity department: 4.6%

A breakdown of sickness rates by ward/department for each site is below

#### Lincoln County Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
</table>

United Lincolnshire Hospitals NHS Trust Post-inspection Evidence appendix
Specialist midwives 8.4%
Nettleham Ward 8.3%
Midwifery rotational 5.1%
Community Lincoln 4.4%
Bardney Ward 2.0%
Antenatal clinic 1.6%

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

Bank and agency staff usage

The service had low rates of bank and no agency staff used on the wards.

Lincoln County Hospital

The tables below show the numbers and percentages of nursing hours in maternity at Lincoln County Hospital from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Qualified midwifery staff

Of the 168,808 total working hours available, 1.7% were filled by bank staff and 0.0% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 5.3% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018 to February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
<td>Bank usage</td>
<td>Agency usage</td>
<td>Not filled by bank or agency</td>
</tr>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Ante Natal Clinic</td>
<td>16,816</td>
<td>53</td>
<td>0.3%</td>
<td>0</td>
</tr>
<tr>
<td>Nettleham</td>
<td>13,296</td>
<td>114</td>
<td>0.9%</td>
<td>0</td>
</tr>
<tr>
<td>Bardney</td>
<td>29,057</td>
<td>199</td>
<td>0.7%</td>
<td>0</td>
</tr>
<tr>
<td>Midwifery Rotation</td>
<td>109,639</td>
<td>2,577</td>
<td>2.4%</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>168,808</td>
<td>2,943</td>
<td>1.7%</td>
<td>0</td>
</tr>
</tbody>
</table>

Non-qualified midwifery staff

Of the 59,407 total working hours available, 19.1% were filled by bank staff and 0.0% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 6.0% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018 to February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
<td>Bank usage</td>
<td>Agency usage</td>
<td>Not filled by bank or agency</td>
</tr>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Ante Natal Clinic</td>
<td>12,850</td>
<td>2,366</td>
<td>18.4%</td>
<td>0</td>
</tr>
<tr>
<td>Nettleham</td>
<td>27,062</td>
<td>3,607</td>
<td>13.3%</td>
<td>0</td>
</tr>
<tr>
<td>Bardney</td>
<td>19,495</td>
<td>5,402</td>
<td>27.7%</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>59,407</td>
<td>11,375</td>
<td>19.1%</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)
Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. All staff received a full induction whether they were bank or agency and all staff on the maternity unit rotated often to maintain competencies in all areas.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service mostly had enough medical staff to keep women and babies safe.

Please note that the trust’s medical staff work across both maternity and gynaecology.

**Trust level**

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for maternity and gynaecology.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>20.6</td>
<td>21.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>19.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Total</td>
<td>39.6</td>
<td>41.0</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the medical staffing rate within maternity and gynaecology was 96.5%. This was higher than the rate of 91.2% in the more recent period from April 2018 to February 2019.

As there was only one team based at each site, these are represented in the site breakdown above

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

The medical staff did not always match the planned number on all shifts in each department, however the service managed this well and we saw no evidence of impact on women who used the service.

**Vacancy rates**

The trust did not have an overall target vacancy rate however, Lincoln County Hospital Maternity Unit reported an 11% vacancy rate, significantly higher than the trust vacancy rate of 5.6% for medical staff in maternity and gynaecology.

**Trust level**

From April 2018 to March 2019, the trust reported a vacancy rate of 5.6% for medical staff in maternity and gynaecology. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital maternity department: 11.0%

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

**Turnover rates**
The Lincoln County Hospital Maternity and Gynaecology Unit had turnover rates significantly above the trust target of 8% and slightly higher than the trust overall rate for medical staff.

**Trust level**

From April 2018 to March 2019, the trust reported a turnover rate of 22.6% for medical staff in maternity and gynaecology. This was higher than the trust target of 8.0%. Turnover data for medical staff includes trainee grades which may have inflated the rate.

- Lincoln County Hospital maternity department: 24.5%

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

**Sickness rates**

The service had sickness rates at or below the trust target.

**Trust level**

From April 2018 to March 2019, the trust reported a sickness rate of 6.4% for medical staff in maternity and gynaecology. This was higher than the trust target of 4.5%.

- Lincoln County Hospital maternity department: 3.3%

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

**Bank and locum staff usage**

Please note that the trust confirmed that they were unable to provide accurate establishment hours by department and location in all cases. Therefore, we have not calculated the proportion of hours filled by bank and locum staff or left unfilled as this may be misleading.

**Lincoln County Hospital**

As there was only one team based at this site, the table above shows the number of medical hours in maternity and gynaecology at Lincoln County Hospital from April 2018 to March 2019 that were covered by medical and locum staff or left unfilled.

Over this time period, 1,494 were filled by bank staff and 8,873 hours were covered by locum staff to cover sickness, absence or vacancy for medical staff. The trust was unable to fill 824 of the available hours with either bank or locum staff.

*Source: Routine Provider Information Request (RPIR) – Medical locum tab*

Managers could access locums when they needed additional medical staff. The service had high usage of locum staff due to difficulties in recruitment, however the trust were actively promoting the vacancies and had planned open days. Managers made sure locums had a full induction to the service before they started work. All medical staff we spoke with said they were provided with an induction pack and were supervised closely. They reported they felt very supported during their induction period and beyond. They had presentations, clinical supervision from the first week, two objective, structured assessments in training for example caesarean sections and instrumental deliveries.

**Staffing skill mix**

The service had a good skill mix of medical staff on each shift and reviewed this regularly.
In January 2019, the proportions of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust were lower than the England averages.

**Staffing skill mix for the 45.6 whole time equivalent staff working in maternity 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>32%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>59%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>4%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

The service always had a consultant on call during evenings and weekends. Data relating to Obstetric consultant cover showed 60 hours a week over the period of January to December 2018. The Royal College of Obstetricians and Gynaecologist (RCOG) 2007 guidelines it states that for a unit with less than 2500 deliveries a year, the unit must continually review staffing to ensure adequate cover based on local needs. Staff informed us staffing was regularly reviewed and we saw this in minutes of meetings held within the division.

Staff informed us they were happy with medical staffing including overnight medical staffing. They informed us they always had cover at night. Consultant presence on the unit was from 9am to 5pm Monday to Saturday and in the morning on Sunday. Staff also had access to a consultant on call, located within 30 minutes travel time to the hospital.

There was dedicated anaesthetic cover provided 24 hours a day with an on call anaesthetist available to cover women who needed to go to theatre.

**Records**

**Staff kept detailed records of women’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

Patient notes were comprehensive and all staff could access them easily. The trust had moved towards an integrated electronic patient record system which would incorporate antenatal and post-natal care for women and intrapartum care remained largely paper based. We reviewed eight sets of records across the unit, individual records were documented and managed in a way that kept people safe. All paper records were completed fully and accurately, legible, secure and showed plans of care with actions required clearly and concisely. All electronic records were password protected and had easily identifiable user entry.

When patients transferred to a new team, there were no delays in staff accessing their records. Main hospital notes included medical details from previous pregnancies or medical conditions. Staff told us notes were readily available for clinics or admissions.
Records were stored securely. We saw all records trolleys were locked on each ward area, CTG readings were stored securely and labelled correctly. We checked eight prescription charts which were all kept with the women’s notes.

We were told that spot checks were carried out, however there was no robust auditing of the record keeping system to ensure that standards were being maintained.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Controlled drugs (CDs) (a medicine that is controlled under the Misuse of Drugs legislation 2001), were stored appropriately in a locked cupboard and the keys held separately from the main keys. We checked the physical stock of the CDs against the stock level recorded in the register and saw evidence of daily checking by two midwives in each clinical area. There was no pharmacy input throughout the maternity service at Lincoln County Hospital, however a request had been made for the provision and was under consideration.

Staff appropriately prescribed, administered and supplied medicines to women and babies in line with relevant legislation, current national guidance and best available evidence.

Staff reviewed patient’s medicines regularly and provided specific advice to women about their medicines. The hospital used paper prescription and medication administration record charts for patients. We looked at eight prescription charts across the maternity wards at Lincoln County Hospital. Of the charts we looked at we saw they had the woman’s name recorded on every page of the chart and the prescriber’s signature was always legible. Staff recorded women’s allergies on the prescription chart. The records showed patients were getting medicines when they needed them, and any reasons for not giving women their medicines were recorded. These meant women were receiving their medicines as prescribed.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. Medicines were managed, transported, stored and disposed of safely and securely. We checked drug cupboards and ward trolleys and found them to be locked and secure. Intravenous fluids were stored in locked rooms in all areas, this minimised the risk of them being tampered with. We saw emergency drugs and fluids were stored with other emergency equipment which was not locked away and saw they were stored in tamper evident containers which was in line with guidance from the Resuscitation Council UK.

Staff followed current national practice to check patients had the correct medicines. Where medicines reconciliation was needed, ward staff completed it as there was no pharmacy service to the wards. A business case had been submitted for pharmacy team support for the ward.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff were aware of safety alerts and recalls we were told about a feedback mechanism such that the trust was assured appropriate actions had been taken. Good examples of shared learning across the sites was evidenced.

Staff provided information to patients on their medicines. We heard of an example of an MDT for a planned admission of a woman with complex meds associated with her MH treatment involving a range of clinical and support agencies.

**Incidents**
The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff reported all incidents that they should report.

Staff reported incidents through the trust’s electronic incident reporting system. Staff working within the governance and risk teams used the electronic system to provide feedback given in response to staff reports and recorded all the evidence relating to the incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed three investigation reports and found appropriate investigations had taken place. We saw root cause analysis (RCA) investigations had taken place in relation to serious incidents. (Root cause analysis is an approach for identifying the underlying causes of why an incident occurred). We reviewed the serious investigation reports for three maternity incidents and saw there had been a full investigation with input from the multi-disciplinary team. Learning from the incident had been recorded along with agreed actions, for example reviewing guidelines or changes to practice and escalating concerns to senior medical staff.

Managers debriefed and supported staff after any serious incident. Staff at all levels were able to tell us how to report an incident and told us they received feedback both on individual incidents they reported and on incidents that affected their unit. Senior staff debriefed or supported staff involved in serious incidents.

Staff reviewed incidents at speciality governance meetings, monthly matrons meetings and at staff meetings.

Staff met to discuss the feedback and look at improvements to patient care. A perinatal and maternal mortality and morbidity presentation was held monthly and involved multidisciplinary team members (MDT). All cases presented by the medical staff had been through the risk management process. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. We reviewed presentations from the last three meetings and saw staff reviewed cases in detail with areas of good practice highlighted, together with learning outcomes.

Staff understood their responsibility under the duty of candour regulations and we saw examples of the correct process being followed from our review of RCA reports.

**Never events**

The service had no never events on any wards.

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

From March 2018 to February 2019, the trust reported no never events for maternity.

*(Source: Strategic Executive Information System (STEIS))*
Managers shared learning with their staff about never events that happened elsewhere. Learnings from incidents within the trust and elsewhere as well as learning from never events in other trusts were shared during handovers, team meetings, on staff notice boards and newsletters.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from March 2018 to February 2019.

Breakdowns of the serious incidents by type and trust site are shown in the table below:

**Lincoln County Hospital**

In accordance with the Serious Incident Framework 2015, Lincoln County Hospital reported three serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from March 2018 to February 2019:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident: baby only (this include foetus, neonate and infant)</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Maternity/Obstetric incident: mother and baby (this include foetus, neonate and infant)</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Maternity/Obstetric incident: mother only</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff understood their responsibilities about the Duty of Candour (DOC) regulation and were aware of the trigger for the application of duty of candour, which was for moderate harm and above. DOC 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 received feedback from investigation of incidents, both internal and external to the service. We were told by all staff we spoke with they received feedback when requested after reporting an incident. They were given feedback usually through the electronic system.

There was evidence that changes had been made as a result of feedback. (provide information about improvements in safety specific to this service) The wards had ‘Learning to Improve’ folders which contained incidents that had occurred and been investigated and the learning that had come from them to improve the service. For example, following a still birth, recommendations were made for carbon monoxide monitoring to be offered at every appointment in pregnancy in accordance with trust policy.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

Safety thermometer data was displayed on wards for staff and patients to see. Maternity services took part in both the classic and the maternity national safety thermometer scheme. The Classic
Safety Thermometer is a measurement tool for improvement that focuses on blood loss over 500ml, perineal tears (tears to the area between the vagina and rectum during birth), maternal infection, the psychological well-being of the mother and the baby’s health scores in the first 10 minutes after birth. Data for this was collected to indicate performance in key safety issues. The Maternity Safety Thermometer is a national system that was designed to support improvements in patient care and experience. The maternity thermometer also records data on one day a month, the proportion of mothers who have experienced harm free care. It records harm associated with maternity, such as perineal trauma, abdominal trauma, postpartum haemorrhage, infection and women’s psychological perception of safety. We saw safety thermometer data displayed within the unit.

Staff used the safety thermometer data to further improve services. We saw that senior staff reviewed performance measures during governance meetings as well as other unit meetings and made recommendations for improvement. For example, the combined specialty governance and business report for May 2019 indicated a risk assessment tool was being developed to identify women with risk factors for PPH.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Women’s physical, mental health and social needs were holistically assessed, and their care, treatment and support delivered in line with legislation, standards and evidence based guidance, including the National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG).

We reviewed five cardiotocograph (CTG) traces across the maternity unit. Documentation standards were consistent and in line with the trust’s fetal monitoring guideline. Staff carried out hourly ‘fresh eyes’ on the CTG traces. ‘Fresh eyes’ is an approach which requires a colleague to review fetal monitoring readings as an additional safety check to prevent complications from being missed. The process is recommended by NHS England’s Saving Babies Lives; A care bundle for reducing stillbirth.

The trust had fully implemented the NHS England’s Saving Babies Lives care bundle. Elements included reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movements and effective fetal monitoring in labour.

We were told by service leads that the trust’s antenatal key performance indicators (KPI) monitored performance against nine NICE maternity standards. Performance was monitored for seven of the standards against either acceptable (green) or achievable standards (amber). We formally requested this data following the inspection, however the trust did not provide this.

We reviewed guidelines in maternity at random and saw some were out of date, however each of those were either being reviewed or awaiting ratification. There was an audit and quality midwife who was responsible for guidelines, they were kept on the trust intranet and service leads told us their guidelines management had improved considerably over the past 12 months. This gave us some assurance all guidelines were in line with any new evidence or recommendations and women were getting the safest and most effective care and treatment.
The trust had a specialist perinatal mental health midwife, all staff said they were very supportive and were easily accessible for advice across all sites.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We saw any potential mental health issues or emerging risks were raised in handovers and discussed to identify and support the women and relatives may require.

There were clear policies and procedures in line with best practice guidelines. These included National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). This included the ‘Safer childbirth: minimum standards for the organisation and delivery of care in labour’). These standards set out guidance about the organisation, safe staffing levels, staff roles, education, training and professional development.

Staff had access to guidelines on the trust’s intranet system. We reviewed some of the guidelines and found they were up to date.

Sepsis screening and management was in line with national guidance. The use of the sepsis screening tool was embedded on the unit. There were prompts visible around the unit encouraging staff to “think sepsis” in relation to a range of symptoms.

Women with risk factors for gestational diabetes were identified and offered glucose tolerance testing in line with current NICE guidelines.

The unit took part in national maternity audits such as the Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK).

The unit contributed data from the GROW (Gestation Related Optimal Weight) charts, customised antenatal charts for plotting fundal height and estimated foetal weight as part of the co-ordinated growth assessment programme (GAP).

An audit programme was in place for a range of service wide audits. During the last inspection, we found that many of the audits did not possess timelines including presentation dates. The local audit programme provided following our recent inspection included timelines, planned presentation dates, audit status and completion date.

Audits were carried out to improve local practice. For example, following the introduction of new hypoglycaemia guidelines in February 2018, there had been an 87.5% reduction in admissions with hypoglycaemia as the principle diagnosis.

**Nutrition and hydration**

**Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. The labour ward and wards throughout the unit contained fruit and snacks for women requiring additional food and drink. There were vending machines within close proximity of the wards and a restaurant for public use.

Menus included meals for specialist diets; menu options included vegetarian, vegan, gluten free and halal and could be requested at short notice. Food choices were varied and offered at different times if required.

The maternity service had achieved level one accreditation in the UNICEF Baby Friendly initiative accreditation programme in May 2019. We reviewed the notification when it was received during our inspection, however the UNICEF website had not been updated at that time.
The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding and raise standards of care for all babies. The UNICEF UK Baby Friendly Accreditation has four levels which starts with a certificate of commitment. Stage one assessment is building a firm foundation, stage two is an educated workforce and stage three is full accreditation.

Staff had received training to support new mothers with breast feeding. Ward staff carried out a structured assessment of breast feeding before mothers and babies went home to ensure that feeding was well-established. Women received a guide to feeding and caring for their baby as part of their antenatal information and midwives gave new mothers further guidance before discharge from the postnatal ward.

**Pain relief**

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed women’s pain using a recognised tool and gave pain relief in line with individual needs best practice. Women’s pain was assessed throughout their pregnancy and admission to hospital, they could access pain relief in a timely manner during labour and post-operatively. Women we spoke to confirmed that they were offered pain relief options and given information to make informed decisions. They told us that pain relief was offered and administered in a timely manner.

Pain-relieving gas was piped in all birthing rooms on the labour ward. Stronger painkiller by injection was available for women who required stronger pain relief.

There was a birthing pool on the labour ward that women could use to ease their pain in labour. Women who were assessed as low risk were able to use the birthing pool for pain relief, although staff told us that women who were high risk would have an individual risk assessment and care plan developed with them by medical staff to determine suitability of a birthing pool for pain relief. They had recently updated telemetry for use during water births. (The use of telemetry provides women greater choice and control over their birth experience to facilitate the use of water (Birthing Pool) in labour and birth where their pregnancy and labour has been categorised as high risk and requires continuous fetal monitoring).

Women received pain relief soon after requesting it. Epidurals (an injection of anaesthetic into the spinal area) were available for women on the labour ward 24 hours per day, seven days per week. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance states the average waiting time for women requesting an epidural to receiving one should be within 30 minutes. The trust did not collect this information on the maternity IT system, however it was documented within the maternity notes during labour. An audit was completed yearly by the obstetric anaesthetists to determine compliance with this standard and was presented at governance meetings. The trust made a request to the IT Midwife to determine if they could adapt the system to include this data. The trust provided the data following the inspection which showed the mean waiting time for epidurals over the past 12 months was 20 minutes, some were as timely as ten minutes. Labour ward coordinators also reported they had good relationships with anaesthetist and had no issues with attendance by the anaesthetic team.

Staff prescribed, administered and recorded all pain relief accurately. An assessment of pain was included and scored on the MEWS chart and we saw staff escalated to anaesthetists if they were caring for women and could not control their pain, for example post caesarean section.
Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. The service had been accredited under relevant clinical accreditation schemes.

The service maintained a maternity dashboard which reported on clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008.

At the last inspection, the trust did not set local goals for each of the parameters monitored. During this inspection, we found the trust had set local goals for parameters monitored. Data was rated red, amber or green (RAG). This meant staff could assess the data against trust targets.

We reviewed the maternity dashboard following the inspection. Lincoln County Hospital, for the period between April 2018 and March 2019 showed the proportion of women experiencing 3rd and 4th degree tears (overall rate) was 1.99% on average compared with the trust target of 3.5%.

The proportion of women having induction of labour was rated red at an average over the period of 37.7%, significantly higher than the target of 28.5%.

Managers used information from the audits to improve care and treatment. Service leads explained they had implemented the Saving Babies Lives Care Bundle to help to reduce the rate of stillbirths. However, this also had the effect of increasing the induction rate.

The dashboard presented data relating to activity, antenatal, intrapartum, perinatal, quality indicators and risk. This included data on the number of deliveries, broken down into mode of delivery, trauma at delivery (postpartum haemorrhage; excessive blood loss or perineal trauma 3rd and 4th degree) and neonatal unexpected admission to the neonatal unit. The dashboard captured the number of women who had an induction of labour, and the number of antenatal bookings performed before 10 weeks gestation were also captured.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further.

Improvements had been made to increase sonography capacity such as short-term additional lists on Wednesdays, Fridays and Saturdays across both sites, which was due to end when the renovations are completed in October 2019. A new ultrasound scanner had been purchased, however it was unable to be installed until the building work was completed.
Improvements in hypothermia in babies, all babies wear hats. Service leads acknowledged more work was required in the theatre area as the room was cold. Skin to skin contact was always encouraged.

In December 2018, Maternity Voices 15 step challenge was completed, however the report was not available for us to review during our inspection.

**National Neonatal Audit Programme**

**Lincoln County Hospital**

The table below summarises Lincoln County Hospital’s performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids? <em>(Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity)</em></td>
<td>83.0%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery? <em>(Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy)</em></td>
<td>60.9%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Neonatal Audit Programme)

**National Maternity and Perinatal Audit Programme**

**Lincoln County Hospital**

Lincoln County Hospital submitted data to the 2017 National Maternity and Perinatal Audit Programme. However, the hospital did not pass the audit’s data quality checks to produce the majority of the metrics.

The proportion of live born babies at the hospital who received breast milk for the first feed and at discharge from the maternity unit was 74.2% compared to the England average of 74.1%. This was in the middle 50% of trusts.

**Standardised Caesarean section rates and modes of delivery**

From January to December 2018, the total number of caesarean sections was as expected. The standardised caesarean section rates for elective and emergency sections were also as expected.

**Standardised caesarean section rate (January to December 2018)**
### Caesarean Rate

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>United Lincolnshire Hospitals NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.8%</td>
<td>637</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>16.5%</td>
<td>706</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>29.3%</td>
<td>1,343</td>
</tr>
</tbody>
</table>

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode. This table includes all deliveries, including where the delivery method is ‘other’ or ‘unrecorded’.

In relation to other modes of delivery, from January to December 2018, the table below shows the proportions of deliveries recorded by method in comparison to the England average. The trust had a similar profile of deliveries by recorded delivery method when compared to the England averages.

### Proportions of deliveries by recorded delivery method (January to December 2018)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections(^1)</td>
<td>1,343</td>
<td>28.6%</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>478</td>
<td>10.2%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>2,877</td>
<td>61.2%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>4,698</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.
\(^1\)Includes elective and emergency caesareans
\(^2\)Includes forceps and ventouse (vacuum) deliveries
\(^3\)Includes breech and vaginal (non-assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

### Maternity active outlier alerts

As of 29 April 2019, the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

### MBRRACE-UK Perinatal Mortality Surveillance Report

The table below summarises United Lincolnshire Hospitals NHS Trust’s performance in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016:

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts with similar service provision</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilised and risk-adjusted perinatal mortality rate</td>
<td>5.0</td>
<td>Up to 10% higher than the average for the comparator group</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)
The trust’s stillbirth report 2018 was completed to identify themes and trends in order to understand the rise in the stillbirth rate at the trust and to support initiatives to reduce the stillbirth rate within the maternity service. The report identified causes of stillbirths to include abruption, fetal abnormalities and intrauterine growth restriction. The report identified multiple risk factors which increased the risk of stillbirths for the mothers involved. These included being over 35 years old, smoking, mental illness, obesity, complex health conditions such as diabetes and living in a low socio-economic area.

An action plan was created following MBRRACE-UK Perinatal Mortality Surveillance Report, which addressed the underlying causes of the higher risk adjusted perinatal mortality rate in comparison to other trusts.

The action plan included 12 recommendations. It identified action required, a lead responsible for completing the action, date to be completed and update on action. One of the recommendations in the action plan was to reduce the number of women who smoked at the time of birth through clear referral to smoking cessation pathways as smoking was a recurrent theme. It also recommended that women should not have their ultrasound scans cancelled unless critical. Staff were to ensure that high risk women had appropriate personalised care plan.

The trust had implemented the Saving Babies Lives care bundle which was designed to reduce stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based practice; reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movement, effective fetal monitoring during labour.

**Competent staff**

**The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. A trust wide clinical education team monitored midwife competencies to make sure they were up to date with current practice based on national benchmark standards. In addition, the matron had oversight and had regular meetings with ward managers to identify where compliance was low.

There were systems to ensure staff were competent to carry out their role. Newly qualified midwives had a preceptorship programme. New staff were required to complete competency-based assessments before they could work independently. They went through an orientation program designed to make them familiar with all aspects of maternity care.

Multidisciplinary update days were held annually to ensure they had the right skills and knowledge to care for women competently. The courses contained core subjects and some additional subjects according to recent trends and themes or changes.
We saw the training included sessions covering emergency care for both mothers and babies. Topics covered included major obstetric emergencies including neonatal resuscitation, haemorrhage and maternal collapse, shoulder dystocia (where a baby’s shoulders get stuck during a vaginal delivery), breech birth, cord prolapse, pre-eclampsia (a serious complication of pregnancy), sepsis and fetal wellbeing and CTG interpretation.

The role of the supervisor of midwives (SoM) was discontinued on 1 April 2017 following changes to legislation. The trust implemented the new A-EQUIP (advocating education and quality improvement) model of midwifery supervision, with professional midwifery advocates (PMAs). All existing SoMs agreed to complete additional training to become midwifery advocates.

The service employed six whole time equivalent (WTE) PMAs to provide support to midwives across the trust, three at Lincoln and three at Boston. PMA provision was under review at the time of the inspection to look at other models but currently had dedicated time each week to provide the required support, which they felt was manageable.

The maternity unit did not provide high dependency care, however should a woman require it they would be transferred to the main high dependency unit on site. Some staff had completed additional competencies to give intravenous antibiotics and care for babies at an enhanced level when working within the transitional care area on Nettleham ward. The transitional care area had four cots available and babies were usually taken to the neonatal unit for intravenous antibiotics, blood tests etc as there was no standard intravenous competency in place for midwives at the time of our inspection and was under development. Service leads told us staff shortages in the neonatal unit meant some babies were transferred to Boston to improve capacity in Lincoln.

Midwives had completed cardiotocograph (CTG) training and the service held weekly CTG review meetings. Senior staff informed us the matron, maternity ward sisters, consultants and risk midwives attended CTG review meetings. They said midwives were welcome to attend if they were free. Senior staff communicated feedback from the meeting to all staff.

A band six development programme was planned to support staff working towards their band seven position.

Some midwives on the wards and in community had completed training in performing the newborn and infant physical examination (NIPE) checks, however they had a resident paediatrician based on the ward who completed the majority of the checks.

Managers gave all new staff a full induction tailored to their role before they started work. There was a dedicated theatre team for the elective caesarean section list on Thursdays including a recovery nurse. Midwives did not ‘scrub’ however, the rest of the week midwives recovered women in a dedicated recovery room and there was a mixture of elective and emergency cases. All midwives had recovery skills and had a period where they were supernumerary. It was included in their preceptorship and induction pack and competencies were assessed and signed off by an experienced recovery nurse or midwife. There was a second theatre which was being prepared for the service to offer more elective procedures, it was expected to be in use three days per week within a couple of months. All staff we spoke with said they felt supported during their induction period and competent in their roles. They had access to additional training should they wish, for example, a midwife told us she found bereavement difficult to deal with and found she avoided it. She requested training to overcome this and was booked on the following week.

Trainee doctors we spoke with were satisfied with the level of support they received from obstetricians. This included regular and ad hoc teaching as well as opportunities for involvement in audit. New doctors and locums went through an induction period when they joined the trust.
The bereavement midwife for the trust arranged numerous study days for all staff which included obstetric consultants, paediatric consultants, accident and emergency staff, nurses, midwives, gynaecology staff, children’s nurses, etc. She also was supported to further her own development, for example, a planned five day course in grief recovery which would then be rolled out for other staff.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work.

**Lincoln County Hospital**

From April 2018 to February 2019, 87.7% of required staff in maternity (and gynaecology for medical staff) at Lincoln County Hospital received an appraisal compared to the trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>8</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>37</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>96</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Service leads told us appraisals were held annually, therefore since the data above is for a ten month period, it may accurately reflect the year end figure. We were told all staff who had not had an appraisal, had one arranged. Staff we spoke to confirmed if they hadn’t had their appraisal, they knew when it was planned for and said they received one every year.

There were enough clinical educators to support staff learning and development. All clinical educators worked trust wide and felt they managed well to support all staff across sites. All staff we spoke with said clinical educators were easily accessible and supportive.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Managers identified poor staff performance promptly and supported staff to improve.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. A multidisciplinary handover took place twice daily on labour ward including medical staff, midwives and anaesthetic staff. The handover included discussions regarding women who were throughout the unit. Staff shared relevant information about the women and their babies, including risks and emotional and social needs. We saw unit introduced the 9@9 meetings and compiled a 9@9 folder for staff to refer to. This meant they held a meeting at 9am each morning, attended by the
matron and discussed issues including staffing levels, routine checklists, changes in practice, learning from complaints and incidents, updates on the unit refurbishment of the unit and education and training opportunities. All handovers and meetings on labour ward were held in a closed staff room using electronic tablets which meant no information was shared at the midwives station, maintaining patient confidentiality.

The trust had a consultant midwife who worked trust wide and described good multidisciplinary working, particularly in diabetes care. Multidisciplinary teams worked well together in a variety of antenatal clinics.

Staff worked across health care disciplines and with other agencies when required to care for patients. All necessary staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment. For example, neonatal teams worked with obstetricians during the antenatal period to produce care plans for babies. Perinatal mental health teams worked together to provide care for women throughout pregnancy.

Staff in all areas of the maternity service told us they worked closely together to make sure women received person-centred and effective care, this included working with healthcare professionals outside of the trust. We observed good interactions between medical staff and midwives on delivery suite during our inspection and in multidisciplinary handovers.

Many women had their antenatal care from midwives in GP surgeries, Children’s Centres and Maternity Hubs in community midwifery services. Midwives reported they had good working relationships with GPs and other community specialists. We saw that midwives completed the child health record (Red book) to handover care to health visitors. There was a process for midwives to inform health visitors of all pregnancies and to alert them to post-natal issues at discharge.

The trust was involved in Lincolnshire’s local maternity system to deliver equitable access to maternity services in Lincolnshire.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. All staff were able to identify potential mental health issues and sought advice from the specialist perinatal mental health midwife where necessary. They knew the process to follow to refer a woman for a mental health assessment and the specialist midwife had close working relationships with the crisis team and Improving access to psychological therapies (IAPT) as part of the perinatal mental health workstream. Staff within antenatal and newborn screening told us of close working relationships with other providers in the local area, to plan care and support women.

**Seven-day services**

**Key services were available seven days a week to support timely care.**

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Labour ward had access to middle grade obstetric staff 24 hours a day, with the consultant on call as a minimum standard. There was 24-hour access to a dedicated obstetric theatre and a theatre team, seven days a week. An anaesthetist was immediately available for emergency work on labour ward.

Staff told us they had access to diagnostic services such as x-ray, ultrasound, computerised tomography, echocardiography and pathology.

The antenatal clinic was open from 8.30am to 5.00pm five days a week, however the maternity assessment centre offered a 24 hour contact number and was staffed between 8.30am and 12
midnight. Outside of these hours women could contact the dedicated number and be diverted to labour ward. If they required monitoring or hospital admission they went straight to labour ward from 20 weeks gestation.

Community midwives made home visits and held antenatal and postnatal visits seven days a week.

**Health promotion**

**Staff gave women practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Healthy eating and weight management advice was also provided as part of diabetic care for women both before and during pregnancy. Specialist midwives held clinics for diabetic women and provided training for midwives to care for and support women with diabetes. All other women also received support on feeding choices, smoking cessation and healthy eating.

The bereavement midwife arranged regular fundraising and awareness events within the local community. For example, an event during a local football match to raise awareness to a predominantly male audience regarding reduced fetal movements.

Staff assessed each women’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Initial booking risk assessments and ongoing screening monitored and identified abnormalities or risk factors for example raised body mass index, low blood haemoglobin levels and smoking. These were then discussed and care planned with all relevant parties, including women and partners.

Carbon monoxide testing was offered to all women, regardless of their smoking status.

Women were offered a vaccination for whooping cough in every pregnancy between 16 weeks up to 32 weeks pregnant.

The trust website provided information relating to women who were planning a pregnancy, information about during pregnancy, labour and birth, after your baby is born and a range of leaflets to download.

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

**Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit women’s liberty appropriately.**

Medical staff informed women about the risks and benefits of obstetric procedures, such as emergency caesarean sections or instrumental deliveries. Written consent was obtained from women prior to surgery. Staff asked for verbal consent from women prior to any procedures or care.

Staff had access to specialist midwives who had particular expertise in dealing with women in vulnerable circumstances. Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients’ records. When patients could not give consent, staff
made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Specialist midwives supported staff to look after women with additional needs. Where possible staff worked with women to plan care to support them to make choices, gain consent and reduce distress during birth.

Post-mortem examinations were offered to families in all cases of stillbirth and neonatal death in order to enhance future pregnancy counselling. Consultants or registrars gained consent from women for all post-mortem examinations.

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

All nursing and midwifery staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Most medical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the Trust's target. The data below shows the trust target was not met for medical staff, however low numbers of staff have impacted on the rates.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The MCA training delivered covers all levels required and DoLS training is included in the same session so is not reported separately.

Please note that the trust’s medical staff work across both maternity and gynaecology.

**Lincoln County Hospital**

A breakdown of compliance for MCA/DoLS training modules for qualified nursing staff in maternity at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Mental capacity act</td>
<td>128</td>
<td>131</td>
<td>97.7%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In maternity the target was met for the MCA/DoLS training module for which qualified nursing staff at Lincoln County Hospital were eligible.

A breakdown of compliance for MCA/DoLS training modules for medical staff in maternity and gynaecology at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Mental capacity act</td>
<td>5</td>
<td>8</td>
<td>62.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity and gynaecology, the target was not met for the MCA/DoLS training module for which medical staff at Lincoln County Hospital were eligible. However, the completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff knew where to access relevant policies and know who their safeguarding midwife and safeguarding lead was to access them easily for advice should they require it.
Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. The trust kept a log of all patients held under DoLS, however it was very rare it would be used in the maternity unit.

**Is the service caring?**

**Compassionate care**

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Friends and family (FFT) data showed an improvement in the number of women who used the service and those who are close to them who responded positively about the way staff treated people.

Staff were discreet and responsive when caring for women. Staff took time to interact with patients and those close to them in a respectful and considerate way. Women’s concerns were listened to and staff spent time discussing care and options. They took time to interact meaningfully and in a considerate way. Staff discussed the impacts on families from pregnancy through to the postnatal period.

Patients said staff treated them well and with kindness. We observed staff introducing themselves at shift change and saw them caring for women and babies in a compassionate manner. To gain a better overall understanding of the care provided, we spoke with eight women and their relatives who confirmed that they were treated well and with kindness and respect. Women told us that they were offered pain relief regularly and it was administered in a timely manner.

We saw some patient feedback displayed on the wards. There were lots of thank you cards and photographs displayed on all wards from women who had experienced good care.

Staff followed policy to keep women’s care and treatment confidential. We saw staff respecting women’s privacy and dignity. Curtains were drawn wherever possible and side rooms were available for privacy.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. Midwives that we spoke with demonstrated good understanding of women’s needs and showed sensitivity towards them and their families. They acknowledged when women had different physical or mental health needs and a specialist mental health midwife worked across the trust for additional support.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff understood and respected the variety of cultural, social, religious and personal needs of the women. There was a specialist bereavement midwife and several midwives with an interest in bereavement, who were able to signpost bereaved families to a range of additional support to meet individual needs and beliefs.

**Friends and Family test performance**

From March 2018 to February 2019 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally better than the England average.

In the most recent month, February 2019, 100% of mothers recommended the trust for antenatal care, compared to the England average of 95%.
Friends and family test performance (antenatal), United Lincolnshire Hospitals NHS Trust

From March 2018 to February 2019 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally better than the England average.

In the most recent month, February 2019, 98% of mothers recommended the trust for births compared to the England average of 97%.

Friends and family test performance (birth), United Lincolnshire Hospitals NHS Trust

From March 2018 to February 2019 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally better than the England average.

In the most recent month, February 2019, 95% of mothers recommended the trust for their postnatal ward which was the same as the England average.

Friends and family test performance (postnatal ward), United Lincolnshire Hospitals NHS Trust

From March 2018 to February 2019 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally better than the England average.

In the most recent month, February 2019, 100% of mothers recommended the trust compared to the England average of 98%.
Friends and family test performance (postnatal community), United Lincolnshire Hospitals NHS Trust

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2018

The trust performed about the same as other trusts for each of the 18 questions in the CQC maternity survey 2018.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a member of staff help you within a reasonable amount of time?</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Was your discharge from hospital delayed?</td>
<td>5.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed after the birth, did a member of staff help you within a reasonable amount of time?</td>
<td>7.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations</td>
<td>7.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Question</td>
<td>Rating</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.0</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.6</td>
<td>About the same</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)

A high proportion of women gave positive feedback about the service in the Friends and Family Test survey. The feedback from the Friends and Family Test was positive for all wards. Friends and family (FFT) data showed 100% of women recommended the trust for antenatal care in February 2019 and 100% of women recommended the trust generally for maternity services. FFT results for all wards were above the England average, with the exception of the postnatal care which was the same as the England average.

The trust performed similarly to or better than other trusts for all 18 questions in the CQC maternity survey 2018.

**Emotional support**

**Staff provided emotional support to women, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.**

We observed staff supporting women with feeding and talking through options to encourage them to make their own choice. We witnessed a student midwife offering continued feeding support to one woman who confirmed that support was available to her at all times to help her to maintain consistency in feeding. Staff spoke with great enthusiasm which was visibly evident in their work.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Support was appropriate and timely to help them to cope emotionally in their care and treatment. Services were available to all women and families throughout the antenatal and postnatal period including bereavement, domestic violence, counselling and perinatal support.

Midwives supported families to collect keepsakes such as photographs and imprints of the baby’s hands and feet after they experienced a loss as part of their bereavement service.

Staff told us women’s physical and psychological needs were regularly assessed and addressed whilst in the maternity unit. These assessments included nutrition, hydration, pain, personal hygiene and anxiety. Women we spoke with told us all their needs had been met. All of the women and families we spoke with were complimentary of the care they received, one new father told us “I could not have wished for better staff and care of my partner and new baby, throughout labour and on the ward. Staff are always kind and ready to help”.

There was a chaplaincy service available across the trust as well as multi faith and support for women and families of no faith. All staff knew how to access the services and spoke highly of the services that were provided. The service was accessible and worked very closely with the maternity bereavement service.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Midwives with a special interest in bereavement had training on delivering difficult news and all midwives were supported by a specialist bereavement midwife who worked across the trust. The bereavement midwife arranged training days regularly for all staff including chaplains, administrative staff, porters and mortuary staff to ensure there was better awareness and understanding across the whole service and for consistency.
Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with demonstrated an understanding of the impact that their care and treatment had on the overall experience of the women and their families. Staff regularly assessed women’s mental health, both in the antenatal and postnatal period, using recognised assessment tools in line with National Institute for Health and Care Excellence (NICE) guidance.

Midwives specialising in perinatal mental health, safeguarding, diabetes and weight management and bereavement were among a variety of additionally skilled staff, as well as infant feeding and screening coordinators available to work closely with women and other agencies to ensure that they are supported through difficult circumstances and receive continuity of care in the community.

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

**Staff supported women, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Women told us that staff kept them fully informed about their care and treatment and they felt included in the decisions around the care that they received. Women were empowered to have a voice so they could have the best possible birthing experience. Birthing partners were included and involved in the care of their partner and new-born baby and in some circumstances, they could stay and support them, making use of the guest bed which was available on each ward.

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed a lot of interactions between staff and woman and relatives to be kind and friendly with a manner which made them approachable.

Staff supported women to make advanced decisions about their care. Women were asked antenatally about their birthing plans as well as post-partum care preferences, which were documented within the women’s notes to ensure any advanced decisions were considered and acted upon where possible.

Staff supported women to make informed decisions about their care. Staff gave time to explain to women the options available for their care and the care of their baby, for example we observed discussions with women about breastfeeding and bottle feeding and it was entirely the woman’s choice. The staff ensured they were provided with all of the information verbally with written information available and additional support with breastfeeding if they chose that method.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Women were either referred to maternity services by their GP or could refer themselves to the hospital. Women were provided with relevant information about their pregnancy and care at the maternity unit and could access a range of information on the trust website through pages, leaflets and videos. The service provided information through their own digital platform and other social media.
Mothers were provided with a newborn pack, which included relevant information about services they could access.

Community midwives offered antenatal booking appointments in community premises, such as GP surgeries, Children’s Centres and Maternity Hubs. Community teams covered a specific geographical area. This helped to ensure women had access to midwives in their local area. The service provided continuity of care for women before and after birth. In line with this, community midwives booked women for antenatal appointments. All the women we spoke to in the antenatal clinic confirmed they had a named midwife in the community.

Women over 20 weeks attended the antenatal assessment unit for assessment of pregnancy specific concerns including reduced fetal movement, CTG monitoring or for concerns about pre-eclampsia.

There was also an option of home birth, which accounted for 146 deliveries across the trust between 31 December 2017 and 31 December 2018.

Women had access to antenatal classes ran by midwives. This included active birth classes and other classes for women who had complex needs, for example weight management or diabetes.

The trust had employed specialist midwives to provide extra support to women and families with more complex needs. These included a consultant midwife leading on better births, newborn screening midwives, safeguarding midwives, mental health specialist midwives, diabetes specialist, infant feeding midwife and midwife sonographers.

The service did not provide a designated midwifery led unit, although women could use any of the two rooms which had been modified to provide a more homely feel and midwife led care while awaiting the completion of the renovation to the maternity unit.

The labour ward had additional facilities for women with low-risk pregnancies to use a birthing pool, relaxing lighting, birthing balls and stools.

The trust had an active maternity voices partnership and was also an active participant with Lincolnshire’s Local Maternity Systems to deliver Better Births Strategy and Implementation Plan for Lincolnshire.

Facilities and premises were not always appropriate for the services being delivered. The maternity unit was being renovated to improve the flow of the unit for the women’s experience and to make some facilities more appropriate such as a new bereavement suite which will be located in a quieter environment beside the theatres and will have a designated entrance and exit for bereaved families.

The bereavement specialist midwife worked the hours the service demanded, however they supported and trained staff to provide care for families after a pregnancy loss. They provided guidance to staff to ensure all women and families were offered appropriate care at all times and supported to make informed decisions at a difficult time. The bereavement midwife had provided training and raised awareness with both internal and external contacts.

We visited the bereavement room, situated on Nettleham Ward at one end of the ward close to the office areas. The location was not ideal as bereaved women had to deliver their babies on the labour ward and then walk through the unit to Nettleham Ward, through the ward to the bereavement room. Although the location and room were not entirely appropriate for the service, leads had recognised this and work was ongoing to relocate to a new suite where women will be able to deliver and remain in the suite for as long as they need. It is planned to have a dedicated entrance and exit for bereaved families to avoid seeing or hearing other babies and families. At the
time of our inspection, the bereavement midwife made arrangements for lifts to be halted wherever possible when a family was making their way in or out of the area to minimise distress of seeing new families.

Families were able to stay together in the room; a radio was provided to try to minimise any external noise. There were books available for all members of any family and particularly books for children to help them to understand their loss. The service provided information on grieving for a variety of communities, such as grieving in the travelling community as there are many travellers within the local area.

It had a facilities for making drinks and food could be provided or brought in. Women and their families could stay for as long as they wished, and staff provided cuddle (cold) cots to ensure babies could stay longer with their parents. The cuddle cots could be taken home should the family wish to spend time with their baby at home and specialist cold car seats could be provided. A local funeral service with which the bereavement service had close links, bought six cold cots which they took out to families homes so that the hospital cots could remain there. The bereavement midwife had secured charitable funds to enable interim changes to be made to improve the service while awaiting the new suite. They bought homely furnishings to make the room less clinical and made plans for a better bereavement service at Pilgrim Hospital. They found some babies were so small, it was difficult to find clothing and families couldn’t cuddle their babies easily. The bereavement midwife campaigned for women to donate their wedding dresses to the service and were overwhelmed with the response. Volunteers made clothes of every size and made small, satin sleeping bags for tiny babies to be cuddled better.

The service had close links with the chaplaincy service, bereavement office and local funeral services for example, the Imam who provided additional support for families of their faith and helped to facilitate communication and arrangements in a timely way.

Memory boxes, which included photographs and hand and footprints were made up for parents who suffered a pregnancy loss. A local charity provided a photography service for families to have taken, as many photographs as they liked, and parents were given a memory card containing all images for them to keep and seeds for flowers such as forget me nots. The boxes also contained a lock of hair and information about additional support services as well as two blankets and two small teddy bears, one to be given to parents and one to stay with the baby. Memory boxes were provided from several different companies so parents were able to ‘mix and match’ items they chose to make their own memory box. For example, one faith did not want any reminder but a small angel to keep. Crafts were provided for children as distraction. One child with autism wanted a blanket to keep with him and remember his loss, the service bought a blanket and had it blessed by the church for them.

They provided birth certificates for babies who would not be formally registered and arranged naming ceremonies.

The bereavement midwife reported to the Child Death Overview Panel and the Perinatal Mortality Review Panel as well as MBRRACE and followed the National Bereavement Pathway.

The trust stillbirth report had recently been completed and the service had done a lot to raise awareness of reduced fetal movements. The bereavement midwife arranged an event at a local football match to raise awareness amongst men. They had stands with information, made staff available for advice and had a local radio announcement to reach people travelling to the match.

The bereavement midwife managed well to provide the service across the trust with the support of midwives with a special interest in bereavement and bereavement champions throughout the...
sites. However, they felt they would benefit from another specialist bereavement midwife within the trust.

Staff could access emergency mental health support 24 hours a day seven days a week for women with mental health problems, learning disabilities and dementia. The service had good links with community mental health teams and specialist midwives were easily accessible for support at any time.

The service had systems to help care for women in need of additional support or specialist intervention. All staff we spoke with knew how and when to contact for additional support and advice when a women required specialist interventions such as safeguarding and perinatal mental health support.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted.

**Meeting people’s individual needs**

The service was inclusive and took account of women’s individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

All women were assessed at booking for birth place choice. Community midwives supported and promoted home births.

Midwifery Continuity of Carer (MCoC) as part of the Better Births Initiative was in the early stages of implementation by the trust and staff spoke enthusiastically about the benefits to women once fully implemented. MCoC is the central model of maternity care across the UK and the enablement of women to have real choice about place of birth. The provision of care by a known midwife throughout the pregnancy, labour, birth and postnatal period can be associated with improved health outcomes for the mother and baby and greater satisfaction levels.

The trust was working on a targeted approach; however, it was very early stages therefore we did not have access to any data at the time of our inspection.

Staff made sure women living with mental health problems or learning disabilities received the necessary care to meet all their needs. Mental health and wellbeing were discussed with all women throughout pregnancy. These discussions included difficult and sensitive issues such as previous experience of poor mental health, domestic violence, sexual abuse, drug use, female genital mutilation and child sexual exploitation.

The service had information leaflets available in languages spoken by the patients and local community. There was a wide range of information available on the trust’s website for maternity in a number of different languages including Arabic, Urdu, Bengali, Hindi, Polish and Slovakian. Some were also available in large font and audio. The service had access and regularly used interpreters on all of the wards.

We saw there was a wide range of leaflets available and up to date information displayed in all of the clinical areas, they included sleep safe, breastfeeding, bottle feeding, flu vaccine and skin to skin contact with your baby.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. An interpreting service was available for non-English speaking women and hearing impaired. Staff we spoke with knew how to access the interpreting services and said they were used often.
Women were given a choice of food and drink to meet their cultural and religious preferences. Food and drink were accessible to women at all times on the wards and a choice of food including vegan, vegetarian and halal were provided.

**Access and flow**

**Women could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.**

Managers did not monitor waiting times to ensure women could access services when needed and received treatment within agreed timeframes against national targets. Although women told us they could access the service when they needed it, the trust did not routinely audit waiting times to ensure they were in line with national standards.

During the period April 2018 to March 2019, an average of 93.1% of women booked their maternity appointment by 12+6 weeks of pregnancy. This was slightly above the target of 93%.

At the last inspection, the trust did not collect data relating to the percentage of women seen by a midwife within 30 minutes and if necessary by a consultant within 60 minutes during labour. We requested for this data following our recent inspection, but it was not provided.

However, we noted good patient flow across the maternity units. Women in labour were provided 1:1 care and staff attended promptly to women on the maternity ward.

Managers worked to keep the number of cancelled operations to a minimum. The elective caesarean section list was one day only, therefore some elective operation on other days could be delayed due to emergency procedures taking precedence. However, women were informed of this and understood. They were taken to theatre as soon as practicable. Women had good access to emergency theatre 24 hours per day.

Women informed us they found it easy to make appointments with the antenatal team. Some of the women we spoke with had been in the unit for over an hour, although they had already seen a midwife and were waiting to have a scan. The trust did not routinely audit waiting times for women seen in the antenatal clinic.

Staff across the service used an electronic system to monitor bed vacancies and inductions of labour.

The trust provided data following the inspection which showed there were six unit closures over the last 12 months due to capacity. There were escalation processes which included community midwives to work on the unit and training cancellation.

**Bed Occupancy**

From July 2017 to December 2018 the bed occupancy levels for maternity were higher than the England average, with the trust having 88.8% occupancy in 2018/19 quarter 3 compared to the England average of 58.2%.

The chart below shows the occupancy levels compared to the England average over the period.

<table>
<thead>
<tr>
<th>England Average</th>
<th>This Trust</th>
</tr>
</thead>
</table>

United Lincolnshire Hospitals NHS Trust Post-inspection Evidence appendix
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Managers investigated complaints and identified themes. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

All staff we spoke with understood the policy on complaints and knew how to handle them. Patient Advice Liaison Service (PALS) information leaflets were displayed in clinical areas and information about contacting PALS was available on the trust’s website.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The women we spoke to told us they were aware about how to make a complaint. They told us they could raise any concern to ward staff if they needed to. Staff had awareness about the complaint process and could signpost women accordingly.

We saw minutes of staff meetings addressed complaints raised by women and lesson learned was shared with the wider team.

Summary of complaints

Lincoln County Hospital

From March 2018 to February 2019, Lincoln County Hospital received 13 complaints in relation to maternity. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>8</td>
<td>61.5%</td>
</tr>
<tr>
<td>Values and Behaviour</td>
<td>2</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)
Facilities  |  1  |  7.7%  
Patient care  |  1  |  7.7%  
Waiting times  |  1  |  7.7%  
**Total**  |  13  |  100.0%  

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

**Number of compliments made to the trust**

From March 2018 to February 2019, there were 1,382 compliments about maternity at the trust.

A breakdown of compliments by site and ward is below

**Lincoln County Hospital**

From March 2018 to February 2019, there were 1,104 compliments about maternity at Lincoln County Hospital. A breakdown of compliments by department is below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of compliments</td>
</tr>
<tr>
<td>Nettleham Ward</td>
<td>750</td>
</tr>
<tr>
<td>Bardney Ward</td>
<td>354</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,104</strong></td>
</tr>
</tbody>
</table>

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

**Is the service well-led?**

**Leadership**

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The maternity service sat within the Family Health Division of a new trust operating model. There was a clear leadership structure across the trust which included a managing director, a clinical director and head of nursing and midwifery.

The maternity service at Lincoln County Hospital was led by a matron. Band 7 ward managers supported the matron across the wards. A Band 7 midwife lead antenatal clinics across Lincoln County Hospital and Pilgrim Hospital.

During the inspection we found clear lines of accountability and responsibility on the units and staff understood their roles and how to escalate problems.

The clinical directors were supported by a team of consultants. Doctors felt supported by the wider team as well as medical colleagues and told us they received good support from the consultants.

Staff informed us the leadership was visible and approachable. Senior local staff told us they met regularly with the head of midwifery and had close working relationship with the divisional leadership.

Some staff told us it could be difficult for leaders of the service to have oversight and involvement of all services over such a vast geographical area, however they felt leaders did the best they could to support staff despite this.
Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a vision to provide excellent specialist care to the people of Lincolnshire and collaborate with local partners to prevent or reduce the need for people to be dependent upon their services. Staff were aware of the trust values; patient centred, safety, excellence, compassion and respect. The trust’s vision and values were clearly visible on information boards in clinical areas.

The trust had a five year strategy 2019 to 2024 which set priorities for the trust and objectives for delivery. The trust aim was to move away from reactive, hospital-based treatment where possible, towards proactive healthcare in partnership with other stakeholders.

The vision for the maternity unit aligned with the trust’s commitment to maintain obstetric services alongside midwifery led units across two sites at Lincoln County Hospital and Pilgrim Hospital. Senior staff informed us they were working towards delivering all standards in line with the better birth strategy and national maternity strategy.

Plans to improve the physical environment of the maternity unit were extensive and underway. The plans were to improve the flow of the unit, to provide a dedicated bereavement suite in a more appropriate place and to improve the theatre provision to enable them to increase the elective caesarean section lists to three days per week, avoiding emergency procedures delaying elective.

The trust was part of Lincolnshire’s Local Maternity Systems (LMS), which was set up by Lincolnshire’s maternity stakeholders (including clinical commissioning groups, providers and service user partnerships) to deliver Better Births Strategy and Implementation Plan for Lincolnshire 2017 – 2020/21. Key details in the plan include increasing the home birth rate, increasing midwifery led care and reduction of the still birth rates.

Senior staff were engaged with delivering the better births strategy and were activity involved with the LMS transformation group.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff reported there was a positive culture within the service. Staff felt they had opportunities to develop in their role and said they had good working relationships with other team members.

Staff said the unit was open and transparent and they could raise concerns with senior staff. Staff understood their responsibility under the duty of candour regulations and could follow the correct process.

Junior doctors confirmed they had access to training and good support from consultants. Nurses also had access to development training.

Staff we spoke with felt well supported at work. We spoke with three newly qualified midwives who all reported they chose to return to Lincoln County Hospital once qualified as they had such positive experiences as students there. One said, ‘I could not have wished for a more supportive team to work in, I would work anywhere across the trust’.
The service supported a number of staff wellbeing initiatives with the aid of the occupational health team. This included the opportunity to benefit from yoga classes, massages and pedicure.

There was a dedicated Freedom to Speak Up Guardian who supported all staff, most staff we spoke with knew who they were, what their role was and how to contact them.

**Governance**

**Leaders operated some effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

The maternity service sat within the Family Health Division alongside gynaecology, breast services and children and young people’s services.

There was a robust governance arrangement within the division. This included monthly speciality governance meetings where senior staff reviewed for example, patient safety, performance, safeguarding, patient experience, clinical effectiveness, risk management and education.

The speciality governance meeting reported to the divisional clinical cabinet which in turn reported to the quality and safety oversight group.

Staff also attended monthly maternity quality review meetings, matron meetings, Band 7 midwives team meetings and maternity ward meetings. There were also weekly Cardiotocography (CTG) review meetings.

Mortality and morbidity presentation were held monthly and involved multidisciplinary team members (MDT). We reviewed presentations from the last three meetings and saw staff reviewed cases in detail with areas of good practice highlighted, together with learning outcomes.

**Management of risk, issues and performance**

**The trust had systems for identifying risks, planning to eliminate or reduce them. Although they were not fully embedded since the trust had implemented a new Trust Operating Model.**

The divisions were devising procedures to be followed trust wide for consistency. During our inspection, we asked to review the local maternity risk register. Local staff found it difficult to retrieve or articulate which local risks were on the risk register. Staff told us they updated the risk register on an electronic system. We noted risks were collated centrally on a corporate/business unit level and staff often required the assistance of the risk manager to add risks to the register.

Following our inspection, we formally requested the local risk register for the maternity, however the trust failed to provide it. Data received from the trust’s routine provider information request included the ‘ULHT Business Unit Risk Registers’ (a 607 page document) which included risks regarding many specialities across the trust. Planned action to reduce each risk were listed, along with the lead responsible for taking action.

There was no clear description for each risk. Each risk was given a generic title with an indication of the business unit it relates to. Each risk identified ‘weaknesses or gaps in control’ which then gave a description of the risk in relation to different specialities (for example, obstetrics, breast surgery and gynaecology). For example, one of the risks on the risk register was titled ‘availability of essential information’. It then provided a breakdown of ‘weaknesses or gaps in control’ regarding three separate specialities within the business unit. In relation to the obstetric service, it stated CTG recordings were prone to fading, becoming damaged or lost during storage and they...
may not be available or legible when required for medico legal purposes. Planned mitigating action associated with this stated CTGs were stored in purpose designed envelopes to minimise damage or loss. In addition, its CTG archiving would be included in the new maternity electronic system.

The risk register contained several duplications. For instance, risks related to the lack of bariatric equipment and facilities were contributory factors under several risk titles and different planned actions were listed.

Four of the nine risks were regarding lack of bariatric equipment and facilities, three of which referred to the maternity unit in Lincoln Hospital. There was no specific reference to location for other risks.

Staff in the antenatal clinic identified scanning capacity as one of the risks on the maternity unit. This was referenced as a contributory factor (or weaknesses or gaps in control) in relation to the risk titled ‘compliance with regulation and standard’. It indicated the trust was only able to offer scans on a four weekly basis to women identified as high risk for ‘small for gestational age’ (SGA) or fetal growth restriction (FGR). The trust was unable to offer routine scanning to women with a BMI of 35 – 39.99. This was not in line with GAP and GROW guidance which states all women identified as high risk for SGA/FGR should be scanned every three weeks. This included women with a BMI that was greater than 35. Actions were agreed and improvements had been made to increase sonography capacity such as short term additional lists on Wednesdays, Fridays and Saturdays across both sites, which was due to end when the renovations are completed in October 2019. A new ultrasound scanner had been purchased, however it was unable to be installed until the building work was completed.

We raised issues regarding the risk register with the divisional leadership team. They acknowledged the risk register was in a board level format with an overarching title that was not appropriate for clinical risk. They informed us they were working with the risk team to have standard operating procedures to manage risks internally.

The service had a risk midwife who reviewed all maternity incidents, themes and trends.

The service conducted monthly audits to monitor performance against established standards. A maternity dashboard provided an overview of performance against some clinical indicators. We noted this was regularly reviewed by staff during clinical governance and staff meetings.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to a range of information to enable them understand performance and make decisions to improvement it. The maternity dashboard was easily assessible and displayed in clinical areas. It was red, amber and green (RAG) rated enabling staff to quickly highlight areas requiring improvement.

Detailed information regarding performance, risks, education and training, incidents and trends were displayed in staff rooms.

Staff informed us they could access information they needed to provide safe and effective care. Staff had access to patient records and this included clinical notes from the multidisciplinary team and results of investigations carried out.
The intranet was available to all staff and contained links to guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained therein. Electronic systems were password protected and we observed staff signing out of systems once they completed their tasks.

**Engagement**

*Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.*

The service engaged with patients through feedback forms. Feedback from patients was positive with the service regularly achieving 100% recommendations on a monthly basis.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. All women, relatives and carers were encouraged by all staff to leave feedback during their admission and on discharge. Feedback forms were available on all wards and staff offered support should they require it.

The service displayed information throughout the unit to educate women about healthy options for pregnancy, services provided by the trust as well as information about what staff were doing. For example, staff use of hand-held devices were displayed in pictorial information to make women aware that staff used electronic hand-held devices to record observations and were not texting on a phone when they should be working.

The trust had an active maternity voices partnership (MVP) which is an advisory group made up of professionals and parents working in partnership, including staff, representatives of clinical commissioning groups (CCGs). The MVP work together to review and contribute to the development of local maternity services.

The trust engaged with staff through emails, meetings, information on notice boards and catch up meetings held on daily basis. Staff informed us they were involved with the planning and designing of the new maternity unit and were looking forward to completion.

The service encourage staff to nominate other outstanding staff for the yearly staff awards evening.

**Learning, continuous improvement and innovation**

*All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.*

The service consistently reviewed incidents, risks and any formal complaints at speciality governance meetings, matron meetings and staff meetings. Learning from incidents, themes and trends were shared with the wider team and displayed within the staff rooms.

One of the trust’s midwives emerged as the Midwife of the Year 2019 for the Midlands region. The midwife was nominated by a local mother. The award was one of the Royal College of Midwives (RCM) Annual Midwifery Awards, recognising the incredible work done by exceptional midwives across the country.

The service was part of the first wave of NHS Improvement Maternal and Neonatal Health Safety Collaborative and were using quality improvement methodology. One of the workstreams was focused on reduced fetal movements. Improvements included improved information for parents, posters, information in a range of languages, wellbeing wallets and engagement event at a local football match.
Improvements had been made to increase sonography capacity such as short-term additional lists on Wednesdays, Fridays and Saturdays across both sites, which was due to end when the renovations are completed in October 2019. A new ultrasound scanner had been purchased, however it was unable to be installed until the building work was completed.

Wards had folders containing all learning from across the trust which appeared well used and kept where they were accessible. We saw one folder at the midwives’ station, one midwife said they had been reading through it on the night shift to check for any updates.
Services for children and young people

Facts and data about this service

The trust provides care for children and young people at Lincoln County Hospital and Pilgrim Hospital. Both hospitals provide paediatric services for children from newborn to 16 years of age including day case and emergency services.

There are 24 paediatric inpatient beds on Rainforest Ward, an eight bedded paediatric day case ward called Safari Ward and 15 level two neonatal unit cots on Nocton Ward.

Lincoln County hospital and Pilgrim hospital were visited as part of the inspection process and each location has a separate evidence appendix and report. Children’s and young people’s services were run by one management team and are regarded by the trust as one service (‘Two sites, one model’). For this reason, it is inevitable there is some duplication contained within the two evidence appendices.

This report relates to children’s and young people’s service provided at Lincoln County Hospital.

The trust had 6,359 spells from January 2018 to December 2018.

Emergency spells accounted for 97.5% (6,197 spells), 1.9% (124 spells) were day case spells, and the remaining 0.6% (38 spells) were elective.

### Percentage of spells in children's services by type of appointment and site, from January 2018 to December 2018, United Lincolnshire Hospitals NHS Trust

![Percentage of spells chart]

### 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>3,748</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>2,609</td>
</tr>
<tr>
<td>This trust</td>
<td>6,359</td>
</tr>
<tr>
<td>England total</td>
<td>1,141,379</td>
</tr>
</tbody>
</table>
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 service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training, with the exceptions of:

- Fraud awareness and infection prevention level one, which had targets of 95%.
- Local fire procedures and fire safety, which had targets of 100%.
- Immediate life support (ILS)/advanced life support (ALS) and medicine management training which had no targets. The trust informed us that the eligible numbers of staff were not available for these two courses and therefore we were unable to calculate completion rates.

Trust level

A breakdown of compliance for mandatory training courses as of February 2019 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>148</td>
<td>150</td>
<td>98.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>147</td>
<td>150</td>
<td>98.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>146</td>
<td>150</td>
<td>97.3%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>144</td>
<td>150</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>144</td>
<td>150</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>144</td>
<td>150</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>143</td>
<td>150</td>
<td>95.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>141</td>
<td>150</td>
<td>94.0%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>139</td>
<td>150</td>
<td>92.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>137</td>
<td>150</td>
<td>91.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>133</td>
<td>150</td>
<td>88.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>47</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>33</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

In children’s services, the target was met for six of the 11 applicable mandatory training modules for which qualified nursing staff were eligible.

The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

A breakdown of compliance for mandatory training courses as of February 2019 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>148</td>
<td>150</td>
<td>98.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>147</td>
<td>150</td>
<td>98.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>146</td>
<td>150</td>
<td>97.3%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>144</td>
<td>150</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>144</td>
<td>150</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>144</td>
<td>150</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>143</td>
<td>150</td>
<td>95.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>141</td>
<td>150</td>
<td>94.0%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>139</td>
<td>150</td>
<td>92.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>137</td>
<td>150</td>
<td>91.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>133</td>
<td>150</td>
<td>88.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>47</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>33</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
In children’s services, the target was met for four of the 11 applicable mandatory training modules for which medical staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

Nursing staff received and kept up to date with their mandatory training.

**Lincoln County Hospital children’s services**

A breakdown of compliance for mandatory training courses as of February 2019 for qualified nursing staff in the children’s services at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud awareness</td>
<td>74</td>
<td>75</td>
<td>98.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>74</td>
<td>75</td>
<td>98.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>73</td>
<td>75</td>
<td>97.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>73</td>
<td>75</td>
<td>97.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>71</td>
<td>75</td>
<td>94.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>71</td>
<td>75</td>
<td>94.7%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>70</td>
<td>75</td>
<td>93.3%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>70</td>
<td>75</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>69</td>
<td>75</td>
<td>92.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>67</td>
<td>75</td>
<td>89.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>66</td>
<td>75</td>
<td>88.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>13</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>24</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital children’s services, the target was met for seven of the 11 applicable mandatory training modules for which qualified nursing staff were eligible.

The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

A breakdown of compliance for mandatory training courses as of February 2019 for medical staff in the children’s services department at Lincoln County Hospital is shown below:

Medical staff received and kept up to date with their mandatory training.
At Lincoln County Hospital children’s services, the target was met for three of the 11 applicable mandatory training modules for which medical staff were eligible. The remaining module had no eligible staff number available and no completion target but had staff members who had completed the module.

The mandatory training was comprehensive and met the needs of children, young people and staff.

Mandatory training included training in basic life support, infection prevention and medicine management training. The mandatory elements were repeated once a year on or near the same date where possible. All staff completed an induction programme.

Staff told us they were responsible for making sure that they were up to date with all of their training. They could access their training records online and were sent reminder emails when their training was due to expire.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, but did not receive specific training in learning, disabilities and autism.

Training related to learning disability and autism was not part of mandatory training. On the wards we inspected there were not specialist learning disability or autism pathways. Instead nurses told us they treated each child as an individual.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The trust used an electronic monitoring system to manage staff mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were automatically alerted when they needed to update their training by the trust’s automatic electronic red, amber and green (RAG) flagging system. However, if staff had fallen behind with their mandatory training, managers would receive notification of this and would speak to staff.

We observed one staff member’s training record and saw the first electronic flag was green, followed later by amber and red signified the date for the training was overdue.

The clinical leads for medical staff received monthly updates in relation to mandatory training. Staff said they felt supported to undertake mandatory training. Training was a combination of electronic learning and face to face classroom-based learning.

### Safeguarding

Staff understood how to protect children, young people and families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training. Nursing staff and allied health professionals received training specific for their role on how to recognise and report abuse.

Trust level

A breakdown of compliance for safeguarding training courses as of February 2019 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>138</td>
<td>150</td>
<td>92.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>137</td>
<td>150</td>
<td>91.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 3 additional)</td>
<td>67</td>
<td>75</td>
<td>89.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>132</td>
<td>150</td>
<td>88.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>132</td>
<td>150</td>
<td>88.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>130</td>
<td>150</td>
<td>86.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services, the 90% target was met for two of the six safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as of February 2019 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February, 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>32</td>
<td>37</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>32</td>
<td>37</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3 additional)</td>
<td>21</td>
<td>25</td>
<td>84.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>29</td>
<td>37</td>
<td>78.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>29</td>
<td>37</td>
<td>78.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>29</td>
<td>37</td>
<td>78.4%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services, the 90% target was not met for any of the six safeguarding training modules for which medical staff were eligible.

Lincoln County Hospital children’s services

A breakdown of compliance for safeguarding training courses as of February 2019 for qualified nursing staff in the children’s services at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>66</td>
<td>75</td>
<td>88.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>66</td>
<td>75</td>
<td>88.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>65</td>
<td>75</td>
<td>86.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>65</td>
<td>75</td>
<td>86.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
At Lincoln County Hospital children’s services, the 90% target was not met for any of the six safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse. However, data showed the percentage of medical staff receiving training did not meet trust target of 90%.

All medical staff we spoke with during our inspection told us they had received level three safeguarding children’s training. However, this was not reflected in the data.

A breakdown of compliance for safeguarding training courses as of February 2019 for medical staff in the children’s services at Lincoln County Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>15</td>
<td>17</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>15</td>
<td>17</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3 additional)</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>14</td>
<td>17</td>
<td>82.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>14</td>
<td>17</td>
<td>82.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>14</td>
<td>17</td>
<td>82.4%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Lincoln County Hospital children’s services, the 90% target was not met for any of the six safeguarding training modules for which medical staff were eligible.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff had received equality and diversity training as part of their mandatory training and were knowledgeable about the protected characteristics. Staff could give examples of how to protect children, young people and families from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Awareness of child sexual exploitation was included in safeguarding training. Staff we spoke with showed a good awareness of these issues and were confident they would recognise possible indicators of child sex exploitation.

Information about safeguarding children was available on the trust intranet and in the clinical areas. We saw a variety of posters and displays about different aspects of safeguarding children designed for staff and patients.

Staff understood their responsibilities in respect of safeguarding policies and procedures. Staff working with children and young people received safeguarding training at level three.

There were up-to-date provider wide safeguarding policies and procedures in place which were accessible to staff through the trust’s intranet site.
Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us if they thought a child had suffered significant harm, they would contact the Social Services emergency duty out of hours and make a referral.

The trust had a safeguarding team which included a medical lead, named nurse and a deputy named nurse who had just started in the role during our inspection. The safeguarding team acted as a duty team to give members of staff advice, training and planned supervision.

We spoke with the children’s safeguarding lead for the trust, they told us they received safeguarding supervision from a specialist nurse at the Clinical Commissioning Group (CCG). The last time the safeguarding lead had supervision was six months ago. However, when we reviewed the safeguarding supervision contract, it stated the requirement for supervision was quarterly. The safeguarding lead did not know when their next supervision would take place. Regular safeguarding supervision is a requirement of the intercollegiate document which states:

*The purpose of clinical governance and supervision within safeguarding practice is to strengthen the protection of children and young people by actively promoting a safe standard and excellence of practice and preventing further poor practice.*

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Staff had good knowledge of how to raise a safeguarding alert and the necessary actions to keep children safe. There was a clear pathway for reporting and dealing with child protection and safeguarding concerns. Staff described the actions they would take if they identified a safeguarding issue; this was in line with the trust policy.

Staff followed safe procedures for children visiting the ward and departments.

The trust had an electronic patient record system which allowed alerts to be flagged when there were safeguarding or child protection concern. This meant that staff could identify when there was a current or previous safeguarding or child protection concern and inform other statutory agencies as appropriate.

Staff followed safe procedures when visitors attended the wards. Access to the wards was through an intercom and a locked door, which could only be opened by a staff member at the front nurse’s station.

Radiography staff explained the process when undertaking x-rays of children or young people suspected of having a non-accidental injury.

**Cleanliness, infection control and hygiene**

The service-controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.9 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.

All ward areas were clean and had suitable furnishings which were clean and well-maintained. There was evidence of cleaning regimes displayed and were visible to the public.

We saw infection prevention and control (IPC) policies and procedures in place that were readily available to staff on the hospital intranet.
Parents we spoke with during the inspection, had no concerns about the cleanliness of the wards and clinical areas. We observed cleaning schedules were available in all areas and staff completed checklists that showed daily cleaning of toys and games in each area was undertaken.

Hand cleansing gels were available and used in all the areas that we visited. We observed staff using hand gels to clean their hands at regular intervals.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly.

Infection prevention and control was included in the trust’s mandatory training programme. The service had effective infection and prevention control procedures in place. Clinic areas we visited during the inspection appeared visibly clean and there was evidence of cleaning regimes displayed. These were visible to the public on each of the wards we inspected.

Staff followed infection control principles including the use of personal protective equipment (PPE).

On all of the wards we inspected, we saw that children with infectious diseases were nursed in single rooms. For example, on Rainforest ward, there was a child with an infectious disease being nursed in single room, signage on room to show the child was being nursed under infectious precautions. Staff were observed to be following the hospital policy and using PPE when caring for the child.

we reviewed the hand hygiene audits for three out patients in May clinic and saw they were all at 100% compliance.

A piece of work was undertaken by the trust between January and March 2019 (quarter four) which changed the way in which hand hygiene was assessed. Prior to this the trust would receive consistent 100% hand hygiene compliance in most areas and recognised that this probably did not reflect actual practice. The trust therefore changed the hand hygiene assessment methodology to better reflect a more accurate position and to show the areas where non-compliance needed support. During quarter four, the infection prevention and control (IPC) team briefed the trust IPC committee to advise that they expected hand hygiene numbers to decline as the new assessment tool was rolled out. This guided the IPC team on where they needed to focus their efforts to support improvements.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

There was a green ‘I am clean sticker’ system in place, which indicated when equipment had been cleaned. We saw that stickers had been placed on a number of pieces equipment, thereby indicating they had been cleaned recently.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Children, young people and their families could reach call bells and staff responded quickly when called.

A call bell system was in place on all the wards we inspected for patients, parents and care givers to ring when they required assistance from the nursing staff or in an emergency. We observed
that when the call bells were activated, staff responded quickly. We observed nursing staff answering the call bells promptly even during busy times on the wards.

Patients and their families told us the staff responded quickly to the call bells and they very rarely had to wait any length of time.

The design of the environment did not always follow national guidance.

During the inspection we observed most outpatient clinic waiting areas to be quiet, with sufficient seating to accommodate all the patients were attending. All clinic signs were clear, hazardous items were out of reach, and sharp corners covered. The service had suitable facilities to meet the needs of children and young peoples’ families. There were clinical wash hand basins located in the examination rooms and examination room doors were closed when they were not in use.

Parents we spoke with had found their clinic area with minimal difficulty. However, the design of the environment did not always follow national guidance, for example, the outpatient’s department clinic waiting area for an x-ray or CT scan had no facilities for children. Staff told us the children would wait with their parents and that sometimes they had to stand as there was not sufficient seating.

If children were awaiting an x-ray or CT scan, staff told us they would try and move them to the front of the queue. During our inspection we saw the roof was leaking in the clinic and there were buckets on the floor to catch the water. Staff told us, the roof had leaked for a long time and that this had been reported on numerous occasions. This meant, the service did not always have suitable facilities to meet the needs of children and young peoples’ families.

Staff carried out daily safety checks of specialist equipment.

There were resuscitation trolleys throughout the outpatient department and on the in-patient wards. We observed that these were accessible and had received the necessary daily and weekly checks and the equipment stored within resuscitation trolleys and grab bags were within expiration dates.

The operating theatres had a paediatric resuscitation grab bag and paediatric emergency drug box. The recovery area had an airway management trolley stocked for children and a paediatric resuscitation trolley. Daily checks were completed of each of these.

The service had suitable facilities to meet the needs of children and young peoples’ families.

The Rainforest ward, Safari (the children’s day ward) and neonatal unit had minimal kitchen facilities for parents to make drinks and or basic food such as sandwiches.

The children’s wards had a play room with age appropriate toys. On the neonatal unit, there was a parent’s room where parents could stay overnight or an extended stay.

The service had enough suitable equipment to help them to safely care for children and young people.

Appropriate fire safety equipment was available, including fire extinguishers that had received a safety check. Fire exits were clearly signposted and fire doors were clear of obstruction.

The outpatient department clinic consultation rooms were fitted with emergency call bells. We saw evidence the bells were checked regularly.

Equipment servicing and repairs were undertaken by the trust’s clinical engineering department, who were responsible for monitoring when equipment was due for servicing. Staff could contact the department to highlight concerns about any items of equipment. Medical device maintenance was managed by a computerised system; jobs requiring attention were red, amber or green (RAG) rated in order of urgency. In addition, there was a blue rating which signified immediate attention
was required. The system tracked equipment and produced up to date information on where equipment was located.

The play areas on the paediatric wards were well equipped with toys and videos to suit different ages. However, in outpatient’s clinic five, the play room was closed as the play specialist had left last year and had not been replaced.

Staff disposed of clinical waste safely.

Waste bins were located in all departments and clear signs and colour-coded bags identified which bins were for clinical and which were for domestic waste. Staff appropriately separated waste prior to disposal, and placed waste waiting for collection in suitable locations. Clinical waste and domestic waste bins were emptied by the cleaning staff and disposed of through the trusts waste disposal procedures. Staff adhered to correct principle for managing and disposing of sharps. Sharps bins were correctly assembled and were not overfilled.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each child and young person and took action to remove or minimise risks. Staff identified and quickly acted upon children and young people at risk of deterioration.**

In the CQC Children and Young People’s Survey 2016 the trust scored 7.8 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 9.5 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.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. For example, we observed staff completing a paediatric early warning score (PEWS). This is a paediatric early warning system which shows clinical manifestations that indicate rapid deterioration in paediatric patients, infancy and adolescence.

During our inspection we observed a nurse undertaking a PEWS early warning score assessment on a child. The PEWS score was assessed as five, this is the highest possible PEWS score and signified the patient must be reviewed urgently by the senior nurse and have an urgent review by senior doctor with minimum of half hourly observations. We observed the nurse followed the PEWS escalation policy appropriately and the child reviewed immediately by senior staff.

Staff completed risk assessments for each child and young person on admission / arrival and updated them when necessary and used recognised tools,

Staff completed risk assessments for each child and young person on admission arrival and updated them when necessary and used recognised tools. we saw during our inspection there were mechanisms in place to identify patients at risk, such as vulnerable children. Details were recorded in the electronic patient records which all clinical staff had access to. For example, we saw an instance of a child on a child protection plan.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. We saw ligature risk assessments on all the children’s ward and the outpatient clinics we inspected. These were undertaken to identity and mitigate the ligature points where patients might try and hang themselves from. All the children’s
wards had ligature proof curtain tracks around the patient’s bed, that would collapse if any weight was attached to them. Ligature cutters were kept in a compartment in all the resuscitation trollies with a notice and a picture of them on the top of the trolley to both notify and remind staff where they were.

Staff used the Situation Background, Assessment and Recommendation (SBAR) tool for escalating cases where babies, children and young people were becoming acutely unwell and the nurses needed to escalate the information to a doctor or senior nurse. The SBAR tool originated from the United States of America Navy, but had been adapted for use in a health care setting. Each section had very specific information to impart. For example, the Background section had five different facts, these included when the last observations were done, the patients admitting diagnosis and their normal condition. At the end of the SBAR, the escalating nurse was prompted to ask the receiver to repeat the information to ensure they had fully understood the reason for escalation.

Nurses we spoke with said they used this escalation tool and found it very informative and helpful. Staff knew about and were able to deal with specific risk issues.

The trust had guidelines for the rapid recognition and assessment of the sick child. The guidance was for health professionals in the hospital setting and was audited annually. Patient record templates contained a comprehensive selection of risk assessments plus prompts, hints and tips for staff based on best practice guidance. For example, the, the Glamorgan score for paediatric pressure ulcer risk assessment and a modified paediatric Glasgow coma scale.

The service assessed paediatric sepsis using the sepsis six, which is a set of interventions which can be delivered by any healthcare professional and must be implemented within the first hour. Sepsis is a life-threatening condition that arises when the body’s response to infection injures its own tissues and organs.

Rainforest and Safari wards undertook a daily sepsis six audit. At the time of our inspection, data showed that both wards were 100% compliant with the sepsis six audit.

Staff were given a Recognition and Management of Sepsis in Children and Young People Workbook & Assessment for Children’s Inpatient and Children’s Assessment Areas.

Patients were not routinely assessed for Venous thromboembolism (VTE). assessment unless there was a clinical need for the assessment to be undertaken. VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE).

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person’s mental health).

The local authority child and adolescent mental health service (CAMHS) crisis response team were based in the emergency department with a view to assessing the patient and preventing inappropriate admission to an acute medical bed if there was a mental health need. If a child required admission, the CAMHS team would review the child on the ward with a view to transferring them to an appropriate environment if required.

Staff completed or organised psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide.

Staff completed risk assessments for children and young people with mental health needs and referred them for appropriate assessment and treatment. For example, if the child or young person was presenting with suicidal ideation or with an eating disorder.

Staff shared key information to keep children, young people and families safe when handing over their care to others.
We attended the daily safety huddle on Rainforest ward, which was held every day after the medical ward round. A safety huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm. These enhance teamwork through communication and co-operative problem-solving, share understanding of the focus and priorities for the day improve situational awareness of safety concerns. We observed those patients at most risk being discussed with the information disseminated to all staff present.

Shift changes and handovers included all necessary key information to keep children and young people safe.

As part of our inspection, we attended handovers on Rainforest ward and on Nocton ward. Nursing staff handovers occurred at each shift change and are meetings which contain the basic information of the patient being discussed. We observed all the patients on the ward had their medical, nursing, psychological and emotional needs discussed during the meeting if this was relevant to their care. Any staffing or capacity issues were also discussed. However, we also observed that if not discussed in main handover, we observed the nurses undertaking a more detailed handover to each other than these issues were discussed for example family situations and any psychological support needed.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of all grades to keep children and young people safe.

Staffing levels were adjusted daily according to the needs of children and young people and the number of nurses and healthcare assistants on all shifts on each ward. During our inspection we saw these matched the planned numbers, however, this was only achieved on Rainforest ward because there were four agency staff who were employed on a long-term basis of between six and 18 months.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance.

The Rainforest ward manager told us staffing had been on the risk register for the past five years International nursing staff had been recruited as part of the trust's recruitment drive, however this had not proven successful and the nurses recruited for the service had transferred elsewhere within the trust shortly after commencing work.

We saw that nursing staffing was on the risk register on Rainforest ward classified as a ‘red risk’ and numbered 12 on the risk register. The risk register numbers were from one which was the lowest to 15 which was the highest risk. The risk register is the document used by the department and ward Managers to register risks at that level that need addressing, and detail actions arising from the risk assessment process in their areas.

Staffing was highlighted as a red risk on Rainforest Ward, Safari Ward, the neonatal unit and the children's clinics.

The ward manager could adjust staffing levels daily according to the needs of children and young people.
The ward manager could adjust staffing levels daily according to the needs of children and young people and the number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers, however, this was only achieved on Rainforest ward because there were four agency staff who were employed on a long-term basis of between six and 18 months.

The service had enough nursing staff of all grades to keep children and young people safe.

One agency nurse we spoke with had been rostered on shifts for 18 months for three to four 12 hour shifts a week. The ward manager told us that the recruitment and retention of nursing staff was a major issue for the ward and for the trust as they were unable to recruit permanent staff.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers.

We saw that nursing and non-nursing levels on the wards we inspected were appropriate.

Royal College of Nursing (RCN), Paediatric Nurse Standards recommend a ratio of one nurse to four patients over the age of two during the day and at night and a ratio of one nurse to three patients under two years of age and night. A ratio of one nurse to two patients is recommended for patients requiring high dependency care. The guidance also recommended at least one Band six nurse on every shift. This was achieved on Rainforest ward through the extensive use of bank and agency staff over a prolonged period of time.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Permanent staff were able to work extra hours and shifts as and when required. If this was not possible, agency nurses were employed. On Rainforest ward, there were four agency staff who were employed on a long-term basis of between six and 18 months.

Managers made sure all bank and agency staff had a full induction and understood the service.

All agency staff were given a full induction to the service which included all the trusts mandatory training requirements as well as an orientation package.

**Trust level**

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for children’s services.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>4.6</td>
<td>6.8</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>68.3</td>
<td>82.5</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>39.0</td>
<td>50.9</td>
</tr>
<tr>
<td>Pan Trust*</td>
<td>17.0</td>
<td>15.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>128.9</strong></td>
<td><strong>155.7</strong></td>
</tr>
</tbody>
</table>

* The trust informed us that some staff worked over multiple sites. These staff are included under ‘pan trust’ above

From April 2017 to March 2018, the nursing staffing rate within children’s services was 82.8%. This was higher than the rate of 78.5% from April 2018 to February 2019. Both the actual number of WTE staff in post and the number of planned WTE staff increased in the more recent period.

Fill rates of more than 100% indicate there were more WTE in post than originally planned.
Lincoln County Hospital

Lincoln County Hospital reported the following WTE nursing staff numbers for the periods below for children’s services.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site name</td>
<td>April 2017 to March 2018</td>
<td>April 2018 to February 2019</td>
</tr>
<tr>
<td>Actual staff</td>
<td>Planned staff</td>
<td>Staffing rate (%)</td>
</tr>
<tr>
<td>Actual staff</td>
<td>Planned staff</td>
<td>Staffing rate (%)</td>
</tr>
<tr>
<td>St Francis School</td>
<td>2.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Nocton Ward</td>
<td>25.4</td>
<td>29.2</td>
</tr>
<tr>
<td>Paediatric clinic</td>
<td>1.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Safari Ward</td>
<td>6.9</td>
<td>6.5</td>
</tr>
<tr>
<td>Community children’s nursing team</td>
<td>3.8</td>
<td>4.5</td>
</tr>
<tr>
<td>Neonatal nurse practitioners</td>
<td>5.0</td>
<td>6.4</td>
</tr>
<tr>
<td>Rainforest Ward</td>
<td>18.9</td>
<td>25.8</td>
</tr>
<tr>
<td>Transitional care</td>
<td>4.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Total</td>
<td>68.3</td>
<td>82.5</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the nursing staffing rate within children’s services at Lincoln County Hospital was 82.8%. This was higher than the rate of 76.6% in the more recent period from April 2018 to February 2019. Although the number of actual WTE in post did not change, the number of planned WTE staff increased leading to a lower fill rate.

Figures of greater than 100% indicate that there were more WTE in post than originally planned.

Vacancy rates

Trust level

Each ward had vacancy rates at or higher than the trust target.

From April 2018 to March 2019, the trust reported a vacancy rate of 21.0% for nursing staff in children services. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital children services department: 23.1%

A breakdown of vacancy rates by ward for each site is below:

Lincoln County Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional care</td>
<td>41.7%</td>
</tr>
<tr>
<td>Rainforest Ward</td>
<td>39.1%</td>
</tr>
<tr>
<td>Neonatal nurse practitioners</td>
<td>23.3%</td>
</tr>
<tr>
<td>Community children’s nursing team</td>
<td>19.7%</td>
</tr>
<tr>
<td>Nocton Ward</td>
<td>9.4%</td>
</tr>
<tr>
<td>Paediatric clinic</td>
<td>8.7%</td>
</tr>
<tr>
<td>Safari Ward</td>
<td>6.3%</td>
</tr>
<tr>
<td>St Francis School</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

Turnover rates

Trust level
Each ward had turnover rates at or higher than the trust target

From April 2018 to March 2019, the trust reported a turnover rate of 6.3% for nursing staff in children services. This was lower than the trust target of 8%.

- Lincoln County Hospital children services department: 5.1%

A breakdown of turnover rates by ward for each site is below:

**Lincoln County Hospital**

Only two wards at Lincoln had turnover recorded from April 2018 to March 2019:

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional care</td>
<td>31.1%</td>
</tr>
<tr>
<td>Nocton Ward</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

**Sickness rates**

**Trust level**

Each ward apart from Safari and Rainforest ward had sickness rates at higher the trust target.

From April 2018 to March 2019, the trust reported a sickness rate of 5.3% for nursing staff in children services. This was higher than the trust target of 4.5%.

- Lincoln County Hospital children services department: 5.6%

A breakdown of sickness rates by ward for each site is below:

**Lincoln County Hospital**

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community children’s nursing team</td>
<td>26.0%</td>
</tr>
<tr>
<td>Paediatric clinic</td>
<td>21.1%</td>
</tr>
<tr>
<td>Neonatal nurse practitioners</td>
<td>8.3%</td>
</tr>
<tr>
<td>Nocton Ward</td>
<td>5.5%</td>
</tr>
<tr>
<td>Safari Ward</td>
<td>4.2%</td>
</tr>
<tr>
<td>Rainforest Ward</td>
<td>2.0%</td>
</tr>
<tr>
<td>St Francis School</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

**Bank and agency staff usage**

The service had a high rate of bank and agency nurses used on Rainforest ward. There were no bank or agency staff employed in the neonatal unit.

**Trust level**

The table below shows the numbers and percentages of nursing hours in children services at trust level from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 241,372 total working hours available, 2.8% were filled by bank staff and 5.4% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 9.2% of the available hours with either bank or agency staff.
Of the 87,248 total working hours available, 5.4% were filled by bank staff and 0.1% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 23.0% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Qualified staff</td>
<td>241,372</td>
<td>6873.7</td>
<td>2.8%</td>
<td>13,098</td>
</tr>
<tr>
<td>Non-qualified staff</td>
<td>87,248</td>
<td>4708.3</td>
<td>5.4%</td>
<td>112</td>
</tr>
</tbody>
</table>

Lincoln County Hospital

The tables below show the numbers and percentages of nursing hours in children services at Lincoln County Hospital from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

**Qualified nursing staff**

Of the 144,127 total working hours available, 4.0% were filled by bank staff and 5.7% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 5.6% of the available hours with either bank or agency staff.

The negative figure for Rainforest Ward indicates that in some situations additional hours were rostered over and above the set establishment.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Children’s clinic 5</td>
<td>2,483</td>
<td>41</td>
<td>1.6%</td>
<td>0</td>
</tr>
<tr>
<td>Safari Ward</td>
<td>12,768</td>
<td>960</td>
<td>7.5%</td>
<td>264</td>
</tr>
<tr>
<td>Neonatal unit education team</td>
<td>10,168</td>
<td>222</td>
<td>2.2%</td>
<td>0</td>
</tr>
<tr>
<td>Rainforest Ward</td>
<td>61,650</td>
<td>3,421</td>
<td>5.5%</td>
<td>7,981</td>
</tr>
<tr>
<td>Neonatal unit &amp; transitional care</td>
<td>57,058</td>
<td>1,131</td>
<td>2.0%</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>144,127</strong></td>
<td><strong>5,775</strong></td>
<td><strong>4.0%</strong></td>
<td><strong>8,258</strong></td>
</tr>
</tbody>
</table>

**Non-qualified nursing staff**

Of the 49,920 total working hours available, 8.1% were filled by bank staff and 0.2% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 12.9% of the available hours with either bank or agency staff.

The negative figure for Rainforest Ward indicates that in some situations additional hours were rostered over and above the set establishment.
<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
</tr>
<tr>
<td></td>
<td>Hrs</td>
</tr>
<tr>
<td>Children’s clinic 5</td>
<td>4,458</td>
</tr>
<tr>
<td>Safari Ward</td>
<td>5,475</td>
</tr>
<tr>
<td>Neonatal unit education team</td>
<td>0</td>
</tr>
<tr>
<td>Rainforest Ward</td>
<td>19,808</td>
</tr>
<tr>
<td>Neonatal unit &amp; transitional care</td>
<td>20,179</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49,920</strong></td>
</tr>
</tbody>
</table>

**Medical staffing**

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff to keep children and young people safe.

The medical staffing levels did always not match the planned number on all shifts in each department.

The proportion of consultants reported to be working at the Lincoln County hospital site was lower than the England average. The Royal College for Paediatric and Child Health (RCPCH) facing the future standards for acute general paediatric services were not met at as there were eight consultant paediatricians, working at this site, however the requirement was for ten.

The Trust operated a ‘Hot Week’ duties for consultants. Each week two consultants would undertake this role (one for paediatrics and one for the neonatal service). However, one of the consultants told us that the locum consultants would not undertake the on-call duties, this thereby placed extra pressure on the permanent consultants.

A paediatric consultant was on call 24/7 and able to attend the hospital within 30 minutes if required.

There was a consultant of the week model however the presence of the consultant on site was from 9am to 5.30pm, Monday to Friday, and 8.30am to 1pm on Saturday and Sunday.

There were medical handovers three times in every twenty-four hours with consultant present at two of the handovers. We observed two medical handovers and found there was an in-depth discussion of each patient and the plan for the patient.

All grades of medical staff told us they received a good level of support from the consultants, who were always available and happy to attend when needed.

Agency consultants refused to undertake on-call duties, thereby adding extra pressure to the substantive consultants.

Managers could mostly access locums when they needed additional medical staff.

The service used a number of locums who had worked at the trust for a significant amount of time and were knowledgeable about the service.

Managers made sure locums had a full induction to the service before they started work.
Locum staff told us they received a comprehensive induction which included all the trusts mandatory training requirements.

**Trust level**

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for children’s services.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>1.6</td>
<td>3.4</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>25.6</td>
<td>31.2</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>17.3</td>
<td>23.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44.5</strong></td>
<td><strong>58.0</strong></td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the medical staffing rate within children’s services was 76.7%. This was higher than the rate of 73.1% from April 2018 to February 2019. Both the actual number of WTE staff in post and the number of planned WTE staff increased in the more recent period.

**Lincoln County Hospital**

Lincoln County Hospital reported the following WTE medical staff numbers for the periods below for children’s services.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Community paediatrics</td>
<td>5.0</td>
<td>6.2</td>
</tr>
<tr>
<td>Paediatrics inpatients</td>
<td>20.6</td>
<td>25.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25.6</strong></td>
<td><strong>31.2</strong></td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the medical staffing rate within children’s services at Lincoln County Hospital was 82.0%. This was higher than the rate of 78.2% in the more recent period from April 2018 to February 2019.

**Vacancy rates**

The service had high vacancy rates for medical staff.

**Trust level**

From April 2018 to March 2019, the trust reported a vacancy rate of 25.0% for medical staff in children services. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital children services department: 17.6%

A breakdown of vacancy rates by ward for each site is below:

**Lincoln County Hospital**

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community paediatrics</td>
<td>21.3%</td>
</tr>
<tr>
<td>Paediatrics inpatients</td>
<td>16.7%</td>
</tr>
</tbody>
</table>
Turnover rates

Trust level
The service had high turnover rates for medical staff.

From April 2018 to March 2019, the trust reported a turnover rate of 35.7% for medical staff in children services. This was higher than the trust target of 8%. Turnover data for medical staff includes trainee grades which may have inflated the rate.

- Lincoln County Hospital children services department: 39.3%

A breakdown of turnover rates by ward for each site is below:

Lincoln County Hospital

Only one ward had turnover recorded in Lincoln County Hospital from April 2018 to March 2019.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics inpatients</td>
<td>49.1%</td>
</tr>
</tbody>
</table>

Sickness rates
Sickness rates for medical staff were low.

Trust level

From April 2018 to March 2019, the trust reported a sickness rate of 1.7% for medical staff in children services. This was lower than the trust target of 4.5%.

- Lincoln County Hospital children services department: 2.6%

A breakdown of sickness rates by ward for each site is below:

Lincoln County Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics inpatients</td>
<td>2.9%</td>
</tr>
<tr>
<td>Community paediatrics</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Bank and locum staff usage

The service had high rates of bank and locum staff on Rainforest ward.

Lincoln County Hospital

The table below shows the number of medical hours in children’s services at Lincoln County Hospital from April 2018 to February 2019 that were covered by medical and locum staff or left unfilled.

Over this time period, 3,720 were filled by bank staff and 5,674 were covered by locum staff to cover sickness, absence or vacancy for qualified nurses. The trust was unable to fill 1,040 of the available hours with either bank or locum staff.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank usage</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Community paediatrics</td>
<td>144</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3,576</td>
</tr>
<tr>
<td>Paediatrics and neonates</td>
<td>0</td>
</tr>
<tr>
<td>Neonatal medicine</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,720</strong></td>
</tr>
</tbody>
</table>

**Staffing skill mix**

The service had a good skill mix of medical staff on each shift and reviewed this regularly. However, the proportion of paediatric consultants working at the trust, was lower than the England average.

In January 2019, 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 52 whole time equivalent staff working in services for children and young people 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>33%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career</td>
<td>29%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>32%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>6%</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

Managers could mostly access locums when they needed additional medical staff.

The trust employed a number of locums on a long-term basis who were knowledgeable about the service.

Managers made sure locums had a full induction to the service before they started work.

All bank and agency staff received an induction.

**Records**

**Staff kept detailed records of children and young peoples’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

Patient notes were comprehensive, and all staff could access them easily.

The service used mainly a paper-based system for recording and storing patient information. All patient records we observed were accurate, up to date and easily accessible.

We reviewed 11 complete sets of patient records (including nursing risk assessments, care plans, observation charts and medical records) and found the records were legible, contemporaneous, signed and dated and contained specific details about patient care. Nursing risk assessments and
care plans were individualised and were updated on a regular basis or when changes in the patient’s condition was noted.

There were systems in place to identify on a child’s record if there was a particular issue such as safeguarding or diabetes. Information was shared with GP’s, school nurses and health visitors through an electronic system used by the trust.

There was a flag system available on the computer admission system at the hospital which identified children who were at risk and for ‘looked after children’ (LAC). The medical records also contained details around the specific risks of the child and any action plans which were in place.

An audit of record keeping undertaken in 2018 of 16 sets of notes showed a number of different common findings, for example drug charts in the notes with no weights recorded, poor handwriting and not putting a line through the gaps in the notes. Recommendations on the findings of the audit included making sure that every patient must have their weight recorded on admission and taking time to make sure handwriting was legible. However, the trust had not undertaken a further record keeping audit to see if improvements had been made.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Staff in the outpatient department clinics told us patient paper records were sent to them a week prior to the patient’s appointment and they checked prior to the clinic to ensure all the records needed were available.

Records were stored securely.

Medical records were stored separately to the nursing risk assessments and care plans, however all healthcare professionals (medical, nursing, allied health professionals, social care) documented updates in these records.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

We reviewed 11 medicines charts and found they were completed appropriately. Medicines were stored safely in locked facilities and the temperature of the room and refrigerators used to store medicines were recorded daily.

Staff reviewed children and young people’s medicines regularly and provided specific advice to children, young people and their families about their medicines.

A paediatric pharmacist visited the wards daily to review the medication charts and provide advice and review medicines prescribed. A junior doctor told us they received good support and advice from the pharmacists. Staff told us the pharmacist also facilitated the timely supply of discharge medicines for the patient to take home.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy.

Staff followed current national practice to check children and young people had the correct medicines. We saw that staff always checked the patient’s identity by asking their name and date
of birth and checking their wrist band before administering medicines. Allergies were clearly recorded on the front of the prescription chart. Patients with drug allergies wore red wrist. This minimised the risk of the patient receiving medications which they were allergic to.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Controlled drugs were stored correctly, and daily checks of stock were completed and documented.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. Medicine fridges were checked daily and documented; staff knew what action to take if they found the temperature to be out of the recommended range.

We observed staff wore red tabards when administering medicines to discourage interruptions as it is recognised that this can be a contributory factor in medicines errors.

Staff were aware of medicine management policies and were able to tell us what they would do in the event of an error. We saw there were decision making processes which were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. However, the trust did not have a policy to support young people managing their own medication.

Blank prescription forms were stored securely.

Staff followed current national practice to check children and young people had the correct medicines.

The pharmacists regularly reviewed the medicines administration charts to ensure all medication was correct dosage for the child or young person.

We observed the administration of medicines and observed nurses and medical staff undertake the appropriate checks and safeguards to ensure the medicines were administered as prescribed.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Staff told us they received from the pharmacy safety alerts and information about medication incidents.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.

We did not see any examples of medicines being used to control behaviour.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them.

All the staff we spoke with were able to explain how they would identify and report incidents using the electronic reporting systems. This meant the provider was able to identify, investigate and learn from incidents. One senior member of staff explained to us they were confident in the systems of reporting and learning.
Staff reported incidents through the trust’s electronic reporting system. Nursing and medical staff understood their responsibilities to raise concerns and to record safety incidents, concerns and near misses.

Staff reported all incidents that they should report.

Staff gave examples of incidents they had reported. For example, one member of staff told us of a safeguarding incident they had reported.

**Never Events**

The service had no never events on any wards.

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

From March 2018 to February 2019, the trust reported no never events for services to children and young people.

Managers shared learning with their staff about never events that happened elsewhere.

Information concerning never events was shared with staff by managers to inform future Practice.

Staff told us they received information on learning and trends from incidents and complaints. Learning from incidents was discussed in staff meetings and specific changes to practice were emailed directly to all relevant staff members.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in services for children and young people which met the reporting criteria set by NHS England from March 2018 to February 2019.

Breakdowns of the serious incidents by type and trust site are shown in the tables below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/obstetric incident: baby only (this include foetus, neonate and infant)</td>
<td>2</td>
<td>66.7%</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>3</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>2</td>
<td>66.7%</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>3</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Lincoln County Hospital**

In accordance with the Serious Incident Framework 2015, Lincoln County Hospital reported two serious incidents (SIs) in services for children and young people which met the reporting criteria set by NHS England from March 2018 to February 2019:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious</th>
<th>% of serious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/obstetric incident: baby only (this include foetus, neonate and infant)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment delay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust-wide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidents</td>
<td>Incidents</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
<td></td>
</tr>
</tbody>
</table>

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong.

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. There was a trust policy relating to duty of candour, which outlined actions to be taken when something went wrong.

Staff were able to give examples of where things had gone wrong and how patients and families had been immediately informed and provided with support, for example where a patient had received a treatment delay.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff were informed about the outcome of complaints and incidents within their area of practice.

Staff told us if a patient, parent, or caregiver had a concern, they would at first try and deal with the issue to resolve it. This demonstrated a pro-active attitude towards concerns and complaints. Staff could tell us what they would do if a patient, parent or caregiver wanted to make a complaint.

Staff met to discuss the feedback and look at improvements to children and young people’s care.

Staff had regular team meetings where improvements to care were discussed.

There was evidence that changes had been made as a result of feedback.

The safeguarding lead told us about how practices had been changed in the trust following a serious case review in 2018 concerning an incident that occurred in the emergency department.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Staff met to discuss the feedback and look at improvements to children and young people’s care.

The senior nurses told us they reviewed all incidents and cascaded learning from incidents. Staff told us they received feedback with learning from incidents in a variety of forms. For example governance meetings, monthly ward meetings, handovers, e-mails to individual staff and safety huddles.

Staff told us they were told about changes to practice as a result of incidents, at handover, by email, in newsletters and in ward meetings. Nursing staff told us that in addition to verbal communication at handover, feedback was also incorporated in the handover summary sheets for staff.

Managers debriefed and supported staff after any serious incident. Any serious incidents would be investigated through the use of root cause analysis and where necessary further training would be arranged.

Managers took action in response to patient safety alerts within the deadline and monitored changes.
Staff told us that children, young people and their families were involved in investigations. Managers debriefed and supported staff after any serious incident. Managers told us they would speak to staff post serious incident and support them if they wished to either speak with the counselling service or the chaplaincy. A member of staff spoke about the availability of support and debriefing they received following a safeguarding incident.

Staff told us about safeguarding group supervision and how incidents that had happened were discussed with learning disseminated and lessons learnt. However, they had not received safeguarding supervision since February 2019, as the member of the safeguarding team who undertook the supervision had left the trust and only just been replaced.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

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

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

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from March 2018 to March 2019 for children’s services.

The service continually monitored safety performance.

Staff told us they did not use the national safety thermometer Instead; monthly quality performance audits were undertaken. This information was visible on all of the wards we inspected.

### Is the service effective?

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. However, not all of the polices were up to date.

Overall, we found that care provided was evidence based and followed recognised and approved national guidance. Staff were clear of their roles in care pathways and were aware of the national guidelines relevant to their scope of practice. However, not all of the polices were up to date. For example, there were two safeguarding policies and clinical guidelines for the management of newly diagnosed diabetes, urinary tract infection and nasogastric feeding. In addition, the standard...
operating procedure for the monitoring of all fridges and freezers used for the storage of medicines expired in 2017.

New policies and procedures were communicated to staff through staff meetings, emails and the weekly updates. However, not all of the policies were up to date, for example All the staff we spoke with were able to demonstrate to us that they received regular communication from the board, head of service and team leaders. For example, staff had access to information about best practice in the form of national and local clinical policies and guidelines. Staff told us they accessed clinical guidelines on the trust intranet. For example The National Institute of Health and Care Excellence (NICE) clinical guidelines which were implemented throughout the patient care pathway. This meant that staff were able to keep up to date with current practice and national guidance.

We saw evidence that patient needs were thoroughly assessed before care and treatment started and there was evidence of care planning. This meant that children and young people received the care and treatment, they needed.

We observed staff giving evidence-based advice to a mother about introducing solid food to her baby at the correct age. This was supported by the staff member giving the mother a leaflet.

Adherence to NICE guidance and local procedures and policies were discussed at team meetings. There were clinical care pathways in place across the organisation, using NICE and other national guidance.

We observed two children in the operating theatre before, during and after a surgical procedure. All checks and procedures were carried out in line with the Association for Perioperative Practice recommendations.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice.

The trust had access to child and adolescent mental health services (CAMHS) for children and young people who had mental health problems. Information on the wards provided guidance for staff including a deliberate self-harm pathway, increased supervision care bundle, and other information, along with the local authority emergency duty team out of hours information for staff.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families.

At both the nursing handovers we attended, we observed staff appropriately discussing children and young people with psychological and emotional needs.

The trust provided us with evidence of clinical audits completed to assess compliance with national and local guidelines.

**Nutrition and hydration**

**Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs.

The children, young people and families we spoke with told us they were always given choices of food and snacks. Patients were positive about the quantity and quality of the food they received in the hospital.
Children told us they liked the food. We saw they chose what to eat from pictorial menus. Drinks were refreshed throughout the day.

All children received an initial review of their dietary requirements on admission. If there were concerns about the child's nutritional status, a referral was made to the dietitian.

Specialist support from staff such as dieticians and speech and language therapists were available for children and young people who needed it.

We observed two children before they went for surgery, we observed the appropriate fasting time was implemented for both children.

Staff fully and accurately completed children and young peoples’ fluid and nutrition charts where needed.

We looked at six fluid and nutrition charts on the wards we inspected and found that staff had fully and accurately completed the charts where needed.

Infants admitted in the neonatal unit were on feeding charts to monitor their milk input. Breast feeding mothers were encouraged to express breast milk so there was a supply for the baby when mum was not present.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition.

Staff assessed children’s nutritional needs on admission to hospital using the MUST screening classification, which is a nationally recognised screening tool. 'MUST' is a five-step screening to identify children and adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.

Specialist support from staff such as dieticians was available for children and young people who needed it.

Staff could refer children and young people to the paediatric dietician for specialist support.

Specialist support from staff such as dieticians and speech and language therapists were available for children and young people who needed it.

A paediatric dietician and speech and language therapist were both based on site and staff were able to refer children and young people to them for specialist intervention and assessment.

**Pain relief**

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young peoples’ pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff prescribed, administered and recorded all pain relief accurately. Pain was regularly monitored on the wards we inspected. Assessments had been completed in all patient files we reviewed. Pain charts had been updated regularly and pain assessments were included in the observation charts.

Staff on the wards used a numerical pain score of zero to three for older children and a five faces chart for younger children and those children with non-verbal communication.

Parents and children told us that pain relief was administered promptly when required.
Children and young people received pain relief soon after requesting it.

We observed pain relief being administered promptly on the ward to a young person post-surgery.

**Patient outcomes**

**Staff did not always monitor the effectiveness of care and treatment and did not always used the findings to make improvements and achieved good outcomes for patients. The service had been accredited previously under the Unicef UK baby friendly Initiative in 2011 and was applying for re-accreditation at the time of our inspection.**

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further.

The service participated in the paediatric diabetes audit. However, did not perform well in the completion of seven key health checks for young people over 12 years of age.

Members of the diabetes team said there was a trust wide action plan to improve following the results of the audit. They told us a business case had been submitted to obtain the resources required to provide point of care testing for patients and a database to monitor care and treatment. There were some ongoing issues with dietetic support due to staff vacancies, although they told us they received excellent support from a psychologist. The trust provided a copy of the action plan with progress against the individual areas for improvement and which confirmed the information we were given.

The trust provided details of their performance in the national diabetes transition audit which compared results for those young people transitioning between children’s and adult services. This showed similar results to the national paediatric diabetes audit reported above.

The service was in the process of working towards accreditation by the Unicef UK Baby Friendly Initiative. There were five stages to meet full accreditation. Data showed the trust had met stage one of the accreditation process in April 2019. The trust had been highly commended for the quality of the documents and the thorough way in which the necessary processes to implement the Baby Friendly standards had been planned. The trust still has to complete stage two, to be fully accredited. The trust had received previous accreditation in 2011, with a stage one accreditation awarded in August 2007 and stage two accreditation awarded April 2011.

The service contributed to the National Neonatal Audit Programme (NNAP) The National Neonatal Audit Programme (NNAP) run by the Royal College of Paediatrics and Child Health (RCPCH). The programme helps neonatal units to improve the care they provide to babies who need specialist treatment.

The service was accredited by the UNICEF baby friendly accreditation scheme at stage one and was in the process of applying for stage two accreditation.

Managers did not carry out a comprehensive audit programme.

Managers did not carry out a comprehensive audit programme, and did not always implement the Recommendations. For example, quality improvement project on the investigation and management of childhood epilepsy in 2018. One of the recommendations of this project was a need for an Implementation of a well-defined integrated care pathway. However, this pathway was not evident when we undertook our recent inspection.

Additionally, there was no epilepsy lead for the trust, or other clinical staff with specialist epilepsy Knowledge.

which meant that improvements were not always checked and monitored and there were not always engagement meetings or follow-up of audit outliers.
The service held regular meetings to review performance in regards sepsis management and patient outcomes. For example, the failure or delay in sepsis screening monthly screening report. The report for February 2019 had 11 cases recorded for failure to screen and the reason for this, three of the cases were upheld.

The service had a sepsis action plan, which included a number of actions to improve sepsis compliance, which included sepsis champions to check all PEWS scores of above five and ensure the correct escalation procedure had been undertaken and to arrange dates for sepsis training on the wards.

A paediatric prescription audit was undertaken by the service in December 2018. The results showed 100% compliance in the documentation of medication, route and frequency. However, the audit also showed poor documentation of the prescriber’s name and signature. As a result, a summary of the Royal College of Paediatrics and Child Health prescription training was made available to all new doctors as part of their induction process.

Managers did not always use information from audits to improve care and treatment as improvements were not always checked and monitored.

However, as a result of sepsis audits, the trust provided additional training to improve the identification and management of sepsis and the sepsis six protocol.

**Paediatric diabetes audit**

The service participated in the paediatric diabetes audit. However, they did not perform well in the achievement of seven fundamental health checks for young people over 12 years of age.

**Lincoln County Hospital**

The table below summarises Lincoln County Hospital’s performance in the 2017 National Paediatric Diabetes Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion rate for key health checks for patients aged 12+ (There are seven key care processes recommended by NICE for patients with Type 1 diabetes that should be performed at least annually)</td>
<td>65.5%</td>
<td>Negative outlier</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted mean HbA1c (HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled. This measure is provided for benchmarking against other providers during an audit year)</td>
<td>67.4</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Median HbA1c (This measure is provided to give an indicator of how performance has changed between the previous and latest audit reports. A change of 1 mmol/mol is deemed to be clinically significant)</td>
<td>63.0</td>
<td>Clinically significant improvement</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

**National Neonatal Audit Programme**

**Lincoln County Hospital**
The table below summarises Lincoln County Hospital’s performance in the 2018 National Neonatal Audit Programme against measures related to paediatric care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do all babies &lt;32 weeks gestation have a temperature taken within an hour of admission that is 36.5ºc-37.5ºc? (Low body temperature on admission is associated with increased complications, such as hypoglycaemia, jaundice and respiratory distress, and death in pre-term infants)</td>
<td>67.8%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission? (Timely consultation with parents/carers is crucial to allaying fear and anxiety and improves the parent/carer experience)</td>
<td>91.4%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Do all babies &lt;1,501g or a gestational age of &lt; 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP) (ROP is a preventable cause of blindness in pre-term infants provided it is detected and treated in a timely way)</td>
<td>96.7%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Do all babies with a gestation at birth &lt;30 weeks receive a documented follow-up at two years gestationally corrected age? (It is important that the development of pre-term babies is monitored by a paediatrician or neonatologist after discharge from the neonatal unit)</td>
<td>53.2%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
</tbody>
</table>

The trust was within expected range for the complete audit.

Emergency readmission rates within two days of discharge

From December 2017 to November 2018 there were no emergency readmissions after elective admission at this trust among patients in the under 1 age group and insufficient admissions for the one to 17 age group to produce any data table for this trust.

The service had the same readmission rates for non-elective care as the England average.

The data in the following two tables shows emergency readmissions within two days of discharge following emergency admission. From December 2017 to November 2018, the trust’s readmission rate for patients aged under one years old admitted to paediatrics was the same as the England average.

Over the same time period, there was a slightly lower percentage of patients aged one to 17 years old readmitted following an emergency admission to paediatrics compared to the England average. No other speciality at the trust had six or more readmissions.
Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (December 2017 to November 2018)

<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>3.6%</td>
<td>1,942</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 (December 2017 to November 2018)

<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>2.6%</td>
<td>3,986</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

Notes: These tables show the three treatment specialties at the trust with the highest volumes of readmissions; only those specialties where the trust had 6 or more readmissions recorded are shown in the tables.

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From January 2018 to December 2018 the trust performed better than the England average for the percentage of patients under the age of one who had multiple readmissions for asthma.

The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma and worse than the England average for multiple readmissions for epilepsy.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 year and 1 to 17 years). (January to December 2018)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td>Under 1</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>1 to 17</td>
<td>13.0%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Under 1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>1 to 17</td>
<td>*</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Under 1</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>1 to 17</td>
<td>30.8%</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’. The “-” (a hyphen) in the table indicates that there were no

United Lincolnshire Hospitals NHS Trust Post-inspection Evidence appendix Page 249
admissions for these long-term condition or age groups.

Managers did not carry out a comprehensive audit programme at Lincoln hospital.

An audit to review the identification and treatment of early neonatal sepsis was completed at in November and December 2018. An action plan was developed, but it was unclear as to dissemination across the trust.

An audit to review compliance with NICE guidance (NG9) on the acute assessment and management of bronchiolitis. It found there was good history taking, and cohorting of children in busy winter periods. However, it also found variations in managing children, which were not evidence based and completion of some investigations which were not clinically indicated. The findings were presented, and an action plan developed, however, there was no information about progress with the actions identified in the plan.

A paediatric prescription audit was completed at Lincoln County hospital and reported in December 2018. This found 100% compliance in the accurate documentation of drug name, does, route and frequency and 100% review of antibiotics and medicines prescribed to be given only when required. It showed poor documentation of the prescriber’s name and signature and 70% compliance with clear demographic details. As a result, a summary of the Royal College of Paediatrics and Child Health prescription training was to be available to all new doctors at induction. The actions from this audit were therefore applied to doctors at the Pilgrim hospital.

Managers mostly used information from the audits to improve care and treatment.

The emergency re-admissions audits within two days of discharge audits above show the readmission rate against the national average. The results of the audits were mostly discussed and, in some cases, actions were identified and completed to improve care and treatment. We saw evidence of the promotion of sepsis and the trust provided information about the additional training and support provided to improve the identification and timely management of sepsis. For example, the sepsis six audits.

There were engagement meetings, although little evidence of follow-up of audit outliers.

Data showed that not all information from audits were discussed or acted upon. For example, the 2018 epilepsy audit.

Managers did not always share and make sure staff understood information from the audits.

There was no identified audit clinical lead for children’s and young people’s services. This meant that information from audits was not always shared widely with staff.

Improvement was not always checked and monitored.

Sepsis audits were monitored; however, we could not find evidence that there was consistent of monitoring, checking and implementation of action plans from national audits.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and families.

Managers gave all new staff a full induction tailored to their role before they started work.
There was a comprehensive induction programme and supporting framework in place for all newly qualified staff and new to area staff, who told us their induction and training was positive and thorough.

Managers gave all new staff a full induction tailored to their role before they started work.

All staff were supported to attend training covering areas such as safeguarding adults and children information governance, medicines management, infection and prevention control and record keeping.

Staff completed a paediatric early warning score (PEWS) competency assessment tool to enable them to accurately identify a deteriorating child. Neonatal service staff attended a development programme one day per year which enabled them to remain current and competent in their practice.

None of the staff we spoke with had received a regular one to one meeting with their line manager, these were only undertaken where it concerned specific aspects, for example applications to attend a training course.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work.

All staff we spoke with said they had regular appraisals, annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being and capability. All qualified nursing, medical and health care support workers we spoke with confirmed they had received a meaningful appraisal within the past year.

**Trust level**

From April 2018 to February 2019, 81.0% of staff within children’s services at the trust received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>31</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>2</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>77</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>104</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>2</td>
</tr>
</tbody>
</table>

**Lincoln County Hospital name**

From April 2018 to February 2019, 85.2% of staff within children’s services at Lincoln County Hospital received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>16</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>2</td>
</tr>
</tbody>
</table>
## Support to doctors and nursing staff

| Qualified nursing & health visiting staff (Qualified nurses) | 59 | 72 | 81.9% | 95% | No |
| Qualified Allied Health Professionals (Qualified AHPs) | 2 | 3 | 66.7% | 95% | No |

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Staff said they had not received safeguarding supervision recently as a member of the safeguarding team who had provided this, left in February and a new person had only just appointed at the time of our inspection.

Managers did not always support medical staff to develop through regular, constructive clinical supervision of their work.

There was no medical lead for safeguarding. Medical staff told us they did not have regular safeguarding supervision.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend.

Staff on Rainforest ward told us if they were off work when there was a team meeting, they were asked to attend and would be paid for their time.

All staff told us that meeting minutes were e-mailed to them.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Training needs were either identified in their yearly appraisal sessions or staff would approach their manager.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff told us managers made sure they received specialist training relevant to their role. For example, one staff member told us she wanted to develop her skills in diabetic care for children and young people and was encouraged to do so by their manager.

Managers identified poor staff performance promptly and supported staff to improve. Managers we spoke with said this was part of their role and they ensured it was undertaken as appropriate.

Managers told us if they identified poor staff performance, the addressed it immediately and through the correct policy and procedure.

## Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care.

There was effective multidisciplinary working between hospitals and teams within hospitals. The services involved multidisciplinary staff working between two hospitals, chaplaincy services, bereavement services, allied health and the local authority child protection social workers.
Staff worked across health care disciplines and with other agencies when required to care for children, young people and families.

We reviewed a case where a safeguarding alert had been raised on a child and saw there was effective multi-disciplinary working between all professionals including outside agencies.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression.

When children and young people were discharged from a service, there were clear mechanisms for sharing appropriate information with their GP and other relevant professionals and to ensure that the child and family fully understand what was happening with their care and any next steps.

Staff were knowledgeable about the requirement for mental health assessments should the patient show signs of mental ill health or depression.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

We observed two referrals to for mental health assessments on patients who had eating disorders. Staff told us the adolescent mental health service (CAMHS) would visit to assess the patient within 24 hours.

CQC Children and Young People’s Survey 2016 – Q23

In the CQC Children and Young People’s Survey 2016 the trust scored 8.9 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.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Children and young people were reviewed by consultants depending on the care pathway.

Consultants were on site until 5.30pm each evening and provided on call cover out of hours. Staff told us they had good access to consultants who were supportive and willing to attend whenever they were required.

After 5.30pm Monday to Friday and after 1pm on a Saturday and Sunday, out of hours consultant cover was provided off site and accessible through telephone communication through the hospital switchboard. A requirement of the trust was that all consultants had to live within 30 minutes of the hospital, so they could attend promptly if there was a situation which required their physical presence.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

There was 24-hour access to the radiology department, seven days a week. However, there was no paediatric specific pharmacy service out of hours or at the weekends. If any pharmacy issues were identified, the service contacted the out of hour’s service that was provided for the whole hospital.

There was access to physiotherapy out of hours for children with complex needs and medical conditions such as cystic fibrosis.

Health promotion
Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every ward/unit.

During our inspection, we observed a number of patient information leaflets available in all the clinics we visited. The leaflets covered a range of issues from infections and illnesses to information about the trust’s complaints procedure. The leaflets were available in different font sizes and were presented in a range of languages.

In the clinics we also saw that nutrition and hydration posters were clearly visible for patients and displayed information on how to obtain a healthy diet.

All clinics and locations had processes in place to meet the needs of patients with a hearing disability. We observed signs which indicated the hearing loop system was in place for those who required it.

There was handwashing gel in all the locations we visited for both staff and patients, with posters next to them on infection control.

Staff assessed each child and young person’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Referrals were made to dieticians for those children and young people who required their input.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care.

We spoke to staff about how and when to assess whether a child or young person had the capacity to make decisions about their care. All staff demonstrated to us they understood their responsibility in gaining consent prior to undertaking an examination or treatment.

Staff made sure children, young people and families consented to treatment based on all the information available.

Parents, children and young people we spoke with told us staff did not provide any care without first asking their permission. All the patient records we looked at, we saw copies of signed consent forms and that consent to treatment was obtained appropriately. The consent process was also available on the trust website.

When children, young people or their families could not give consent, staff made decisions in their best interest, considering their wishes, culture and traditions.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions.

All staff we spoke with were aware of the mental capacity legislation and how this related to young people from 16 years old. Staff told us how they involve the young person as far as possible those close to them and other relevant professionals such as social workers in making a best interest decision.

Staff clearly recorded consent in the children and young peoples’ records.
We saw copies of signed consent forms in the medical and nursing notes we reviewed and saw that consent to treatment was obtained appropriately. The consent process was also available on the trust website.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

All staff we spoke to were knowledgeable about Gillick competencies and Fraser guidelines.

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

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff had a good understanding of the principles of the Mental Capacity Act and Deprivation of Liberty. Training was included as part of the trusts mandatory safeguarding training received.

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The MCA training delivered covers all levels required and DoLS training is included in the same session so is not reported separately.

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards exceeding the trust target.

A breakdown of compliance for MCA/DoLS training courses as of February 2019 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>138</td>
</tr>
</tbody>
</table>

In children’s services the target was met for the MCA/DoLS training module for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>30</td>
</tr>
</tbody>
</table>

In children’s services the target was not met for the MCA/DoLS training module for which medical staff were eligible.

**Lincoln County Hospital**

A breakdown of compliance for MCA/DoLS training courses at Lincoln County Hospital for qualified nursing staff in children’s services is shown below:

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards exceeding the trust target.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>30</td>
</tr>
</tbody>
</table>
In children’s services at Lincoln County Hospital the target was met for the MCA/DoLS training module for which qualified nursing staff were eligible.

Medical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards, but this did not reach the Trust’s target.

A breakdown of compliance for safeguarding training courses at Lincoln County Hospital for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>15</td>
</tr>
</tbody>
</table>

In children’s services at Lincoln County Hospital the target was not met for the MCA/DoLS training module for which medical staff were eligible, although the completion rate was above 85%.

Other CQC survey data

CQC Children and Young People’s Survey 2016 Data

The trust performed about the same as other trusts for four of the five questions relating to effectiveness in the CQC Children and Young People’s Survey 2016. No score was provided for question 54.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Clinical staff were knowledgeable about the terms “mental capacity” and “best interest decisions”, and demonstrated they acted in accordance with the Mental Capacity Act. We also asked these staff about the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty, all of which provided satisfactory answers.

Staff were knowledgeable about both the 1989 and 2004 Children Acts. They had learned about these as part of their mandatory training. One staff member told us of a child who had been part of a section 47 investigation under the 1989 Children Act last year and the involvement they had with the child and other professionals.

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance.

Staff were aware and knowledge about the requirements of the legislation, policies and procedures concerning consent.

Staff told us that managers made sure their training on Deprivation of Liberty Safeguards was up to date and that they knew the legal requirements of this.

Mandatory training was undertaken yearly. Staff told us their managers were notified of the mandatory training requirement date.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

The policy was available on the trust intranet site and staff knew how to access. Staff told us they would contact the safeguarding team or the CAMHS team for advice and assistance.
CQC Children’s Survey questions, effective domain, United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<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>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>19</td>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>33</td>
<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>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>54</td>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 children</td>
<td>No Score</td>
<td>No Score</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-11 children = asked of children aged from eight to 11 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children young people and families. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We found that at all times staff acted in a compassionate and respectful way towards children, young people and their parents. For example, one parent told a nurse that they were worried about their child not sleeping well at night. We saw that the nurse was kind and compassionate in their response and gave appropriate advice and reassurance, offering the parent further support if they felt they needed it.

Information about the availability of chaperones was displayed in the children’s outpatient department.

Children, young people and their families said staff treated them well and with kindness.

We also observed that staff took time to interact with children, young people, those close to them and treat them with kindness and consideration.

Staff followed policy to keep care and treatment confidential.

Staff tried to ensure privacy and confidentiality was maintained during consultations, doors were closed, and voices lowered to ensure other patients could not hear.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs.
Staff were trained and supported in managing children, young people and parents with behavioural or mental health disorders.

We observed that all staff responded in a compassionate, timely and appropriate way when children or young people experienced physical pain, discomfort or emotional distress.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs.

Staff were knowledgeable about the different personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs of them. For example, one young person we saw was a vegan, this is a protected characteristic under The Equality Act 2010. Staff made sure this was well documented and that at meal times, their food was kept separate from non-vegan food.

The trust performed about the same as other trusts for each of the 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 number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>14</td>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>22</td>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42</td>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43</td>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>44</td>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>58</td>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 children</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>64</td>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 children</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>74</td>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 children</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>75</td>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 children</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age  
0-15 adults = asked of parents and carers of children up to 15 years of age  
8-15 children = asked of children aged from eight to 15 years of age

### Emotional support

**Staff provided emotional support to children, young people and their families to minimise their distress. They understood patients’ personal, cultural and religious needs.**

Staff gave children, young people and their families help, emotional support and advice when they needed it.
Trust staff delivered good emotional support. The parents, we spoke with told us there was good communication and emotional support from staff and any concerns were addressed quickly and appropriately.

Staff supported children, young people and families who became distressed in an open environment and helped them maintain their privacy and dignity.

We observed staff offering to take a distressed child back to their side room after they had become distressed in the ward playroom.

The chaplaincy service had a named volunteer chaplain for the children’s wards and neonatal unit. The volunteer although not specifically trained in counselling skills, told us they used their communication skills and experience where bereavement issues and difficult conversations were required. The chaplaincy had memory boxes with a variety of items, for example, teddy bear, lock of hair, baby or child blanket and a candle, thereby inspiring memories for the baby or child that had died.

Staff understood the emotional and social impact that a child or young person’s care, treatment or condition had on their, and their family’s wellbeing.

We observed good staff interactions between parents, babies and children. Staff listened to parents concerns and gave them evidenced based advice. Staff ensured that the parent had understood the information given by using reflective conversations.

Staff understood the emotional and social impact that a child or young person’s care, treatment or condition had on their, and their family’s wellbeing.

The chaplaincy service covered a range of faiths including Anglican, Catholic, Free Church, Jewish and Muslim and was available to provide patients and their families with emotional support. Representatives of other faiths could be contacted as required.

We found that the ‘chaplaincy service’ was proactive and would visit patients and their families on the wards to see if there was any emotional support they could provide.

**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.

### CQC Children and Young People's Survey 2016 questions, emotional support, United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29</td>
<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>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>45</td>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>65</td>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 children</td>
<td>9.5</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>67</td>
<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 children</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age
Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and families understood their care and treatment.

Staff used different approaches to ensure children and young people were involved in their care and treatment. Staff recognised when they had to change how they communicated in order to be understood or enable a young person to be involved.

Staff talked with children, young people and families in a way they could understand, using communication aids where necessary.

We observed staff taking the time to explain treatments to children and young people using language they could comprehend and appreciate. For example, we heard one nurse explain to a child that the “sleeping doctor” (anaesthetist) would be coming to see them before they had their operation.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this.

The service had a twitter page where parents were able to voice their comments (tweet) about the service they were in receipt of. This was real time information and staff were able to view and respond to the parent or care giver (Guardian).

Staff supported children, young people and families to make informed decisions about their care.

Parents told us they felt they were given the opportunity to discuss their child or young person’s care and treatment. They told us the consent process was explained to them and that they felt they could ask questions if there was any aspect they did not understand.

A high proportion of children, young people and families gave positive feedback about the service in the Friends and Family Test survey.

The feedback about the service on the children’s ward was in line with the England average.

The feedback from the Friends and Family Test was positive for all wards.

Patients were happy with the care they received and the NHS friends and family test data was the same as the England average for NHS trust providers.

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for each of the questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<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>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Age Groups</td>
<td>Rating</td>
<td>Comparison</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------</td>
<td>--------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>12</td>
<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>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child's care with you?</td>
<td>0-15 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>15</td>
<td>Did staff involve you in decisions about your child's care and treatment?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>16</td>
<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>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>17</td>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>18</td>
<td>Were you able to ask staff any questions you had about your child's care?</td>
<td>0-15 adults</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31</td>
<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>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32</td>
<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>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>34</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>39</td>
<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>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41</td>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>59</td>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 children</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>60</td>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 children</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>61</td>
<td>Did you feel able to ask staff questions?</td>
<td>8-15 children</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>62</td>
<td>Did the hospital staff answer your questions?</td>
<td>8-15 children</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>63</td>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 children</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>66</td>
<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 children</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>69</td>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8-15 children</td>
<td>9.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>70</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15 children</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>72</td>
<td>When you left hospital, did you know what was going to happen next with your care?</td>
<td>8-15 children</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-15 children = asked of children aged from eight to 15 years of age
12-15 children = asked of children aged from 12 to 15 years of age
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

The trust worked with the local clinical commissioning group and other stakeholders to provide care that met the needs of the local population. Such as the clinical commissioning group and external agencies including Health Education, England, to develop the operating policy for children’s and young people’s services at the Pilgrim hospital, based on the needs of the local population. It was recognised that whilst centralisation of children’s and young people’s services on the Lincoln County hospital site was more economical and more easily sustainable, it would reduce the accessibility of the service for vulnerable groups. The trust provided evidence of regular meetings with stakeholders and their involvement in development of the ‘two sites one model,’ plans for children’s services in Lincolnshire.

The current operating model had been agreed with stakeholders and they were involved in the children's and young people's steering group. Managers and staff were constantly reviewing the operating policy and making adjustments based on local need. However, some of the decisions made in real time were based on responding to a specific patient group’s needs and were not always previously agreed by the trust.

Managers told us they had attended the local Health Overview and Scrutiny Committee and Healthy Conversations Lincs, to discuss children’s and young people’s services at the Pilgrim Hospital.

The hospital allowed flexible visiting times for parents and care givers and provided them with a badge which enabled staff to recognise the arrangement.

There were two parent groups, Kangaroo Club and the Parent Advisory Group. The hospital used the groups for service consultation or to review new documentation such as parent information leaflets.

The trust operated CYP services from three sites. Lincoln, Boston and Grantham, thereby operating a de-centralised service.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Staff were knowledgeable and had a good understanding of the necessities for single sex accommodation and were able to accommodate the mix of age ranges of children and young people attending the children's ward and the day case ward, to enable both privacy and dignity.

Facilities and premises were not always appropriate for the services being delivered.

The environment in the adult outpatient departments where children were frequently seen for example for an x-ray was not suitable for the needs of children. There were no facilities for children. Staff told us the children would wait with their parents and that sometimes they had to stand as there was not sufficient seating.
There were no facilities within the children’s outpatient department for children with additional needs who might be distressed by a noisy environment. The children’s play room in clinic six, had been closed due to the play leader leaving last year and not being replaced.

However, during our inspection we observed most children’s outpatient clinic waiting areas to be quiet, with sufficient seating to accommodate all the patients were attending. All clinic signs were clear, hazardous items were out of reach, and sharp corners covered. The service had suitable facilities to meet the needs of children and young peoples’ families. There were clinical wash hand basins located in the examination rooms and examination room doors were closed when they were not in use. Parents we spoke with had found their clinic area with minimal difficulty.

Staff displayed understanding and sensitivity to children and young people attending the attention deficit hyperactivity disorder (ADHD) and autism clinics; children and young people were greeted and shown immediately to a calm area in order to reduce distress.

There were facilities available for families to stay with their child or young person during their admission in-patient stay. The neonatal unit had three bedrooms, two ensuite, for parents to stay for as long as they needed to. Parents were given free parking subsidised meals and access to hot and cold drinks on the unit.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities.

Staff could call for support from the children’s and adolescent mental health team (CAMHS) and, 24 hours a day, seven days a week.

The service had systems to care for children and young people in need of additional support, specialist intervention. However, planning for transition to adult services was not fully established and only young people with diabetes had access to formal transition clinics.

The trust did not have a transition lead with oversite of the transition process and no specific training available for staff to attend on children transitioning to adult health services.

There was no transition documentation to give parents and no overall transition pathway, or plan for a pathway however, the diabetic and cystic fibrosis pathway was well developed.

Young people attended adult outpatient clinics as part of their transition process. The trust had two transition clinics for children, one for diabetes and one for cystic. However, the transition clinics were not held regularly, due to scheduling difficulties with medical staff from both adults and paediatrics and the travel requirements of staff from a different site within the trust. There were no transition clinics for children with other long-term conditions.

There were no individual transition plans recorded for each child and young people. All actions were documented in the medical, nursing notes and normal care plans.

The trust did not have a transition lead with oversite of the transition process and no specific training was available for staff to attend on children transitioning into adult health services.

There was no transition documentation to give parents, however each young person had a booklet named “All about me” which contained various sections concerning the young person, for example mobility, health needs and how I feel.

Children and young people with on-going nursing needs had an allocated community children’s nurse to coordinate their care and a named consultant for their medical care.

Managers monitored and took action to minimise missed appointments.

The trust had a Patient Access Policy. The policy contained a section on the management of ‘Did not attend’ (DNA’s) appointments. Staff told us that children who did not attend an appointment were always offered a second appointment. We were told if they did not attend the second appointment and could not be contacted by telephone staff would contact the health visitors or school nurses to discuss the situation and a safeguarding referral would made to their local safeguarding authority.
The trust also had a policy on the procedure for a child where there are safeguarding concerns who was not brought or who did not attend appointments including repeated cancellations by the parent or care giver. The policy had clear escalation pathways, which we fund staff were knowledgeable about.

Managers ensured that children, young people and families who did not attend appointments were contacted.

Staff said they did not have a mobile phone text reminder system, but that this was undertaken by the central booking system. Managers did not routinely contact families themselves to explore reasons for non-attendance.

The service relieved pressure on other departments when they could treat children and young people in a day.

At the Lincoln site, there was Safari ward, which is an eight bedded paediatric day case ward.

There was a specialist room available on Safari Ward for forensic examinations of children suspected of having suffered from physical or sexual abuse. If there was a case of suspected child sexual abuse, the child would be transferred over to another location where dedicated facilities were available.

The child and adolescent mental health service (CAMHS) crisis response team were present in the emergency department and reviewed patients with a view to preventing admissions. If a child required admission, the CAMHS professionals would review the child on the ward with a view to transferring them to an appropriate environment if required.

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for each of the 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 number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>5</td>
<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>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>25</td>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>26</td>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>28</td>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>55</td>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 children</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>8</td>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>24</td>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>37</td>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Meeting people’s individual needs

The service did not always take account of children, young people and their family’s individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. However, they coordinated care with other services and providers.

Staff did not always make sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs.

As part of their mandatory training, staff had received a nominal amount of training on caring for children and young people with mental health problems. However, staff told us they would seek advice from the CAMHS team if necessary.

However, there was no provision on the trust electronic patient recording system to make staff aware of any mental health need such as autism or a learning disability of the child or young person.

Staff told us on the wards we inspected there was no learning disability or autism specialist pathway, but that each child or young person was treated as an individual.

However, the waiting area in the operating theatres was child friendly and had pictures on the wall showing a “Bears journey through theatre” which the theatre staff explained to the patient as a way of relieving anxiety.

The anaesthetic room was decorated with child friendly decoration such as cartoons and we observed that general anaesthetics carried out in a very friendly professional manner. We saw two

| 38 | Did a member of staff tell you who to talk to if you were worried about your child when you got home? | 0-7 adults | 8.3 | About the same as other trusts |
| 40 | Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you? | 0-15 adults | 7.3 | About the same as other trusts |
| 56 | Were there enough things for you to do in the hospital? | 8-15 children | 7.5 | About the same as other trusts |
| 57 | Did you like the hospital food? | 8-15 children | 7.5 | About the same as other trusts |
| 71 | Did a member of staff tell you who to talk to if you were worried about anything when you got home? | 8-15 children | 7.4 | About the same as other trusts |
| 73 | Did a member of staff give you advice on how to look after yourself after you went home? | 8-15 children | 8.6 | About the same as other trusts |
| 2 | Did the hospital give you a choice of admission dates? | 0-7 adults | 4.0 | About the same as other trusts |
| 3 | Did the hospital change your child’s admission date at all? | 0-7 adults | 9.2 | About the same as other trusts |

0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-15 children = asked of children aged from eight to 15 years of age
12-15 children = asked of children aged from 12 to 15 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
children anesthetised, on each occasion their mother was with child and was involved fully in what was happening.

The surgical recovery area was specifically for children. There were three spaces which had all the necessary airway management equipment.

One of the volunteer chaplains made sleeping bags for still born babies and babies that had died on Nocton ward and in the maternity unit from wedding dresses donated from nurses. The volunteer chaplain had set up a special social media page for this. The sleeping bags were all individually hand made by the chaplaincy service and were of different sizes.

The chaplaincy service had various different age appropriate memory boxes called ‘Treasured memories’ for the parents of children and babies who had died at the hospital. Each box had a number of different items in, for example, teddy bears, candles, a glass angel in a dome and a container for a lock of hair from the baby or child. There were also comfort bags containing various child friendly items for children who were themselves experiencing bereavement.

In the outpatient’s department there were a number age appropriate of posters with a picture of a toy monkey on with the title “Are you one of monkey’s mates”. The posters covered a number of issues, for example, monkey treats everyone with respect, monkey knows what it is like to be in hospital and encouraging children to ask questions. Monkey says don’t forget to wash your hands with soap. There was also a monkey feedback box where children, adults and care givers placed there feedback comments.

Wards were designed to meet the needs of children, young people and their families.

All the wards we inspected were designed to meet the needs of children, young people and families. There was room in the children or young person side room with beds provided for parents to stay for an extended amount of time or overnight.

On both Rainforest and Safari wards, there was a play room with age appropriate toys.

There were facilities for parents on Nocton ward, the neonatal unit where parents could stay overnight. These had en-suite facilities and there was a separate kitchen when parents could make hot drinks and a supply of basic food stuffs such as milk, cereals and bread.

The children’s outpatient’s department had toys, crayons and paper in the consulting rooms.

Staff did not always use transition plans to support young people moving on to adult services.

During this inspection, we did not see evidence of formal transition plans in place, however, when young people attended transition clinics a record of their visit was documented along with any agreed actions. There was no overall transition pathway and no overall transition lead.

Staff did not always support children and young people living with complex health care needs by using ‘This is me’ documents and passports.

Each child and young person had “This is me” documents which they brought with them to hospital.

Staff told us the trust had devised the ‘ready steady go’ transition plan, which supported children with a long-term illness to transition between children’s and adult services. The plans were produced with the child to identify when the transition would best suit them and improve the experience of transitioning between services. However, we did not see any evidence during our inspection of this being used. The trust had devised “The hidden child across the hospital” documentation. We requested this documentation after our inspection, however, this was not sent to us.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss.

Staff on the wards and post-surgery used a numerical pain score of zero to three for older children and a five faces chart for younger children and those children with non-verbal communication
All staff received training on equality and diversity as part of their mandatory training and were knowledge about disabilities and sensory loss in children and young people.

The service did not have information leaflets readily available in some other languages spoken by the children, young people, their families and local community.

Information leaflets were available for patients to take away, these provided specific advice and education about the relevant speciality being held in the clinic. The information leaflets were in English however alternative presentations for example in braille or larger type font were available. Literature could also be obtained in different languages.

There were information booklets for children of different ages about specific imaging such as X-rays scans, these included pictures so they that could be used for children with no reading skills.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed.

Language support, in the form of face-to-face interpreting, telephone interpreting and written translation was all available. Interpreters rather than family members were used.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences.

We saw the children’s and young people’s in-patient menus, these were suitable to patients of all ages as they described what the food was and also had a picture of it. There were a number of different menu choices available including vegan, gluten free and vegetarian. There were also cultural and religious preferences.

**Access and flow**

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

**Neonatal Critical Care Bed Occupancy**

From February 2018 to May 2018, the trust had a neonatal critical care bed occupancy rate of 0%. However, from June 2018 to January 2019, the trust’s neonatal bed occupancy was 100% in every month. This was higher than the England average. However, bed occupancy should be interpreted with care due to the fact that there are only two neonatal critical care beds available in the trust.

![Graph showing neonatal critical care bed occupancy over time.](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

Managers and staff worked to make sure children and young people did not stay longer than they needed to.
Ward rounds were conducted daily as were handovers, safety huddles and multi-disciplinary assessments and working to ensure children and young people did not stay longer on the ward than they needed to.

Data showed the average length of stay per non-elective admissions in hours for Rainforest ward for January 2019 were 29.2, for February 40.0 and March 34.6. For Safari ward which is the day case ward, for January 2019 the average non-elective stay was 4.7. for February 4.7 and for March 5.3 hours.

Managers had only recently begun to monitor waiting times and make sure children, young people and families could access services when needed and received treatment within agreed time frames and national targets.

The trust had a patient access policy, which described what patients should expect following referral to the hospital. It also included staff training on the policy and annual audit for quality assurance purposes.

There was a paediatric surgical elective task and finish group which met monthly to look at waiting times from the trust data base. However, meeting minutes for April 2019 showed the group had only agreed the terms of reference for the group at that meeting.

The group would be able to undertake monitoring, triage and prioritise children and young people waiting for surgery across the trust.

Managers worked to keep the number of cancelled operations to a minimum.

The trust did not separate data for cancelled surgical operations for children and young people, from overall cancelled operations data for surgery. Six weeks prior to surgery, patients on the operating list were reviewed and then reviewed again at four weeks and then at two weeks. This meant any potential issues were identified and addressed prior to the surgery date.

When children and young people had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

The trust did not keep specific data concerning the cancellation of surgery for children and young people. However, staff told us they tried to not to cancel operations and that this was done only as a last resort and re-arranged as soon as possible.

Managers and staff worked to make sure that they started discharge planning as early as possible.

Each child and young person’s medical, nursing and discharge planning status was discussed on both the daily ward round and the nursing handover. For elective admissions, discharge planning commenced before admission.

All members of the multi-disciplinary team relevant to the child or young person discharge were involved and there were links with local providers and community nurses. For example, we saw a discharge planning meeting had taken place for a child who was known to social services, the named social worker had attended the meeting and therefore been involved in the discharge planning process.

There were no paediatric social workers based at the Lincoln site, only in the community, staff told us, this could sometimes lead to delays in social work in-put.

Discharge planning on the neonatal unit sometimes involved social workers due to any identified risks to their babies care at home.

Staff planned children and young peoples’ discharge carefully, particularly for those with complex mental health and social care needs.

There were multi-disciplinary discharge planning meetings were the child or young person’s discharge form the hospital was complicated in some way, either due to complex health or social care needs. We observed one case where the CAMHS team were involved with the young person and they would be following them up in the community.

Managers monitored the number of delayed discharges.
Managers tried as far as possible to mitigate against bed delays through effective discharge planning. Admissions to the wards were monitored by their hourly length of stay.

Staff supported children, young people and their families when they were referred or transferred between services.

Staff provided advice, emotional and general support to parents when babies, children or young people were transferred to another service.

Staff understood the transferring to another service could be anxiety provoking for those involved and did all they could to mitigate against this.

Managers monitored patient transfers and followed national standards.

The service had a transfer policy. All transfers were monitored and reported to the children’s and young people’s steering group.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints

Children, young people and families knew how to complain or raise concerns.

Parents told us if they had any complaints they would raise them with the ward manager, or the patient advice and liaison service (PALS).

The service clearly displayed information about how to raise a concern in patient areas.

Information was displayed in the ward areas and on leaflets which provided details of how to complain as well as information about the PALS team.

The leaflet explained the process of making a complaint and to whom this could be escalated to if the person complaining was not satisfied with the outcome of the investigation of their complaint.

Manager understood the policy on complaints and knew how to handle them.

Staff told us that complaints were handled in line with trust policy, and that would advise patients to go to PALS if they were unable to deal with concerns directly. Patients would then be advised to make a formal complaint if their concerns remained.

Staff knew how to raise concerns or make a complaint on behalf of children, young people, their families or relatives. There were posters in ward areas which told patients and their representatives how to make a complaint and information on the trust website.

Managers investigated complaints and identified themes.

Complaints were investigated, and any themes noted by managers and fed back to staff.

Lincoln County Hospital

From March 2018 to February 2019, Lincoln County Hospital received 15 complaints in relation to services for children and young people. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>9</td>
<td>60.0%</td>
</tr>
<tr>
<td>Communication</td>
<td>2</td>
<td>13.3%</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>1</td>
<td>6.7%</td>
</tr>
</tbody>
</table>
Values and Behaviour

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>6.7%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting times</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>15</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Number of compliments made to the trust**

From March 2018 to February 2019, there were 438 compliments about services for children and young people at the trust. A breakdown of compliments by site is below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>March 2018 to February 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of complaints</td>
<td>%</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>302</td>
<td>68.9%</td>
</tr>
<tr>
<td>Pan trust</td>
<td>99</td>
<td>22.6%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>35</td>
<td>8.0%</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>438</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The trust noted that, alongside the compliments received by wards and services, there were an additional 746 comments recorded trust-wide. These were comments from patients, families and staff directly to the services and staff they encountered.

A theme from the compliments received trust-wide was good communication.

**Lincoln County Hospital**

From March 2018 to February 2019, there were 35 compliments about services for children and young people at Lincoln County Hospital. A breakdown of compliments by department is below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>March 2018 to February 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of complaints</td>
<td>%</td>
</tr>
<tr>
<td>Clinic 5</td>
<td>26</td>
<td>74.3%</td>
</tr>
<tr>
<td>Safari Ward</td>
<td>9</td>
<td>25.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>35</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Staff told us feedback from complaints were discussed at team meetings and they discussed ways to prevent comparable complaints in the future.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff told us they welcomed feedback from complaints to allow them to develop and improve the service.

**Is the service well-led?**

**Leadership**

The newly appointed leaders had the integrity, skills and abilities to run the service. They understood issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
However, previous leaders had not always managed, or had lacked capacity or resources to manage, the priorities for improvement of the service.

Children’s and young people’s services were managed within the division of family health. The trust had introduced a new model for the management of children’s and young people’s services across the two hospital sites (‘two sites, one model) and the senior management team came into post on 1st April 2019. The team told us they were in the process of establishing roles of responsibilities and recruiting staff to the roles supporting the senior team. For example, a matron was in post for neonates; there was an interim matron in post for paediatrics and a permanent appointment had been made to the matron post. However, it was recognised a lead nurse for children’s and young people’s services was required and the senior management team told us it had not been possible to recruit into the role at the time of the inspection. They were in the process of identifying clinical leads for governance and audit for paediatrics and these were not currently established. Key concerns identified in our last inspection in March 2018, had not been fully addressed and progress had been slow under the previous management structure. However, the newly appointed senior management team had a good understanding of the challenges and had started to put systems and processes in place to address the issues. They were moving forward with the children’s surgery group and establishing a governance structure.

Job plans for consultants had not been reviewed since 2017, although we were told a group job plan was being developed and individual job plans were to being reviewed. During this process, leads for clinical audit would be identified and attendance at 70% of clinical governance meetings would be mandatory.

The matrons and divisional leadership team had responsibilities for children’s and young people’s services across both hospital sites and were based at Lincoln County hospital.

Staff said they were aware of the leadership structures and received good leadership and support from their immediate line managers.

There was a non-executive director (NED) who represented children and young people at board level. Non-executive directors worked alongside other non-executives and executive directors as equal members of the board. They shared responsibility with the other directors for the decisions made by the board and for the success of the organisation in leading the local improvement of healthcare services. This meant the children and young people’s service had a designated person at board level to champion the strategic direction of the children and young people’s service within the trust.

Ward managers undertook ward assurance ward rounds. These included speaking to a sample of patients and relatives, checking patient records and charts, and making sure patients were receiving basic nursing care in line with best practice. Any issues identified during the ward round would be escalated as necessary and feedback given to staff.

The service encouraged staff who wanted to progress to apply for The Mary Seacole Local Programme which is a six-month leadership development programme, to develop knowledge and skills in leadership and management. We spoke with two nurses, who said they had been encouraged to apply for this by their ward manager.

Vision and strategy

The service had a vision for what it wanted to achieve and was developing a strategy to turn it into action, with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
The trust vision was to provide excellence in rural healthcare. Staff we spoke to were aware of the trust values which were Patient Centred, Safety, Compassion, Respect and Excellence.

The trust had a strategy from 2019 to 2024 which set out the priorities for the trust and objectives for delivery. It committed the trust to a system wide approach to improving health and social care across Lincolnshire in partnership with other stakeholders. The strategy committed to providing a paediatric consolidated inpatient (emergency and elective) service for Lincolnshire at Lincoln County hospital and a paediatric assessment unit at Pilgrim hospital, with consultant led neonatal services at both sites.

Staff knew about the trust vision and strategy and all staff we spoke with could tell us about them. Staff told us they were committed to working towards the vision and values of the trust and felt valued in their role.

The trust had collaborated with stakeholders in Lincolnshire to develop plans for the provision of children’s and young people’s services across the county and were partners in the strategic transformation partnership. There was a children’s and young people’s transformation board which reported to the overall strategic transformation partnership (STP) board. This oversaw the development of children’s and young people’s services in conjunction with external stakeholders.

**Culture**

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff spoke about how their main focus was providing excellent care to the children and young people who used the service. This was the one thing they were all proud of and passionate about. Staff were committed to providing and ensuring patients received a good experience.

Staff reported mostly positive working relationships, but morale was mixed. We observed that staff were respectful towards each other. All staff said they felt confident to raise concerns with their managers and felt valued.

The trust had a “Wellbeing wallet” for staff. This has been created after the trusts first managing emotional wellbeing and mental health at work conference. The wellbeing wallet contained information and resources for staff on how to promote a positive emotional wellbeing environment within the trust and where to find more information on how to achieve this.

On the staff engagement board on Rainforest ward, there was a poster that said, “One kind word can change someone’s entire day”. One staff member said they thought of that saying often, especially when things were very busy on the ward.

The trust utilised social media to improve communication with staff.

Morale was mixed, with most staff positive about working for the trust. Other staff said they did not feel listened to and told to just get on with their job. All staff said they were aware of staff shortages and the problems with recruitment.

The trust had a nominated freedom to speak up guardian (FTSUG) who had been appointed by the senior management team without any staff consultation. All the staff, except for senior staff told us they were not confident to speak to the FTSUG and none of the staff we spoke with knew the name of the FTSUG.
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. Duty of candour was not part of mandatory training. However, most of the staff we spoke with had a good understanding about duty of candour.

Staff talked of being open and honest when things went wrong. Senior leaders were aware of duty of candour process and the requirement to send formal apology letters to patient and families when patients had encountered moderate or above harm. There were systems in place to ensure that staff affected by the experience of caring for patients were supported. There were opportunities for formal debriefings as well as informal support.

**Governance**

**Leaders did not operate fully effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities but did not always have regular opportunities to meet, discuss and learn from the performance of the service.**

Clinical governance processes were not fully established and effective; there was a wide variability in staff knowledge about clinical governance meetings and involvement in them. Information was not always cascaded from board to ward in a systematic way. The senior management team explained that the governance framework and meeting structure had been reviewed as part of the new ‘two sites one model’ approach and some parts were more established than others. They told us the terms of reference for each group were being reviewed, to ensure consistency and to ensure the key components of governance were included as standing agenda items.

There were separate clinical governance meetings for paediatrics and for neonates and both met monthly. We were told the neonatal governance meetings were better established and there was good attendance from consultants, senior nurses and managers.

The trust did not provide minutes of the paediatric governance meetings. Minutes of the neonatal governance meetings provided by the trust showed a structured approach with patient safety, patient experience, clinical effectiveness and the risk register as standing agenda items. However, within these sections there was variable review of issues. They did not show evidence of a regular review of incidents (except for some individual incidents on one occasion) and/or review of the timeliness of investigation of incidents, development and review of an annual clinical audit plan, or review of and compliance with new NICE guidance.

The specialty clinical governance groups reported to the divisional clinical cabinet and then to the quality and safety oversight committee.

There was a non-executive director (NED) who represented the children and young people’s services at board level meetings. Senior staff told us they engaged with the NED and they had visited the children’s ward area.

Although there was an identified clinical audit lead for neonates, there was no clinical audit lead for paediatrics. The trust provided a copy of the planned audits for 2019 to 2020, but there were only six audits planned for children and young people’s services across the trust. Minutes of the children’s and young people’s surgery committee demonstrated surgical audits were being considered and a small number were planned for the coming year.

There was a quality and safety improvement plan for children’s and young people’s services. This identified the main priorities for the development of children’s services over a 12-month period. However, we found some of the milestones had not been met. For example, actions such as the development of a robust audit plan to ensure evidence-based care is applied to Children and Young People and suitable, was due to be complete in February 2019. Suitable provision of
activities for children and young people within the environments they are cared for, was to be completed in the same timeframe. Risk registers reflect where national standards/guidance are currently not met with clear plans for mitigation/managing the risk was not complete.

Management of risk, issues and performance

**The trust had effective systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected.**

Governance arrangements were in place for risk management at the time of our inspection. The senior management team said they currently said each ward had a performance dashboard to monitor quality performance indicators for the children’s ward and the neonatal unit.

The trust had developed and introduced a ward accreditation programme to set goals in relation to quality and safety indicators and monitor progress and performance. This had been implemented on the adult wards and we were told a plan was in place to introduce this to children's and young people’s services. The paediatric matron said they monitored data on a monthly basis on performance indicators such as hand hygiene compliance, pressure ulcers, sepsis, staff appraisals, and mandatory training.

The collated information which fed into a governance report which was reported to the divisional governance meetings. They told us the governance committee was starting to challenge and monitor the information.

The service had its own risk register, a risk register is a management tool to facilitate the documentation of risks, actions taken to mitigate the risk, and appropriate resolutions. At the time of our inspection, staffing was the highest risk on the risk register. We were told this was permanently on the risk register and had been for the past five years due to staff recruitment difficulties. There were regular meetings within children’s service to review risks on the risk register and identify new risks. All of the risks we identified during the inspection, were known to the senior management team and were on the risk register.

At the time of our inspection, there was not a systematic programme of clinical audits to monitor practice against national guidance and compare outcomes of care and treatment with other trusts was in place for the current year.

Policies and procedures existed on the trust intranet which staff could access easily. For example escalation policies were in place in the event of fire, water emergencies and computer failure. Staff we spoke with were not aware of these policies.

There were also business continuity plan for each site. Staff on the paediatric ward and the neonatal unit were accustomed to receiving emergency patients that required stabilisation and subsequent transfer to specialist hospitals. They therefore were able to deal with these situations appropriately and were aware of the support and advice available.

Information management

**The service mostly collected reliable data or analyse it. Staff could mostly find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not fully integrated although were secure.**

Patients had their information held confidentially and stored securely electronically. Staff took care to ensure that desktop computers were locked when they were not in use. This meant patient confidentiality was maintained.
Information was not accessible without an appropriate level of security clearance and relevant passwords, which were specific to staff roles.

Patients were involved and consented to the information gathering processes undertaken in the clinics.

There were enough computer terminals in all the clinics visited to enable all staff to access the trust’s intranet, patient record system and external internet information at all times.

Ward sisters had access to data and information to help them monitor their performance and identify where improvements were needed. There was an electronic white board on Rainforest ward which allowed staff to see all of the patients on the ward and their medical and nursing status.

Engagement

Leaders and staff actively and openly engaged with patients, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged with patients and families well. We saw evidence of ways in which the service had integrated patient and family feedback into service improvement. For example, the trialling of a new children’s menu last year.

Parents and family members were given feedback cards, so they could feedback on their experience whilst attending the hospital.

We observed posters in the ward areas highlighting ways parents and children could feedback about their experience and that their experience mattered.

The trust provided us with information about their engagement with local community organisations. In all, they had contacted over 40 groups and attended 24 group meetings. This included children’s centres, church groups, toddler groups, a group for Polish migrants and an international children’s group. At these groups they encouraged people to give their opinions about paediatric services in the county. The trust also held engagement events five of which were held at Pilgrim hospital.

A regular paediatrics newsletter was produced for trust staff, members, stakeholders and others who had registered an interest (affected families). It provided regular updates on the interim service model and an opportunity to feed back.

Staff had regular monthly team meetings. Staff told us they were involved with the agenda and the discussions. Staff were given opportunities to feedback on their roles that they championed.

Staff took part in a staff survey and told us they felt their opinions were taken seriously. Staff and leaders told us they recognised the importance of raising concerns in order for them to be addressed. The lead for medical training in the service received an award in recognition of the improvements to the training programme at the hospital.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services, although progress to improve services was slow. They did not always have a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
The service was in the process of working towards re-accreditation by the Unicef UK Baby Friendly Initiative. The trust had received previous accreditation in 2011, with a stage one accreditation awarded in August 2007 and stage two accreditation awarded April 2011.

The service contributed to the National Neonatal Audit Programme (NNAP) The National Neonatal Audit Programme (NNAP) run by the Royal College of Paediatrics and Child Health (RCPCH). The programme helps neonatal units to improve the care they provide to babies who need specialist treatment.

Rainforest and Safari wards undertook a daily sepsis six audit. At the time of our inspection, data showed that both wards were 100% compliant with the sepsis six audit.

Staff were given a Recognition and Management of Sepsis in Children and Young People Workbook & Assessment for Children’s Inpatient and Children’s Assessment Areas.
Pilgrim Hospital

Urgent and emergency care

Facts and data about this service

Urgent and emergency services are provided by the trust at three sites across Lincolnshire: Lincoln County Hospital, Pilgrim Hospital, and Grantham and District Hospital.

The emergency departments based at Lincoln County Hospital and Pilgrim Hospital provide consultant-led emergency care and treatment 24 hours a day, seven days a week to people across Lincoln and the North Lincolnshire area. Grantham and District Hospital closes overnight.

(Source: Routine Provider Information Request (RPIR) – Acute context)

Details of emergency departments and other urgent and emergency care services

Lincoln County Hospital
• Accident and emergency department
• Paediatric emergency service
• Ambulatory care bay

Pilgrim Hospital
• Accident and emergency department
• Ambulatory emergency care

Grantham and District Hospital
• Emergency assessment unit
• Assessment and ambulatory care
• Accident and emergency department

(Source: Routine Provider Information Request (RPIR) – Sites tab)

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 a waiting and reception area, two triage rooms, 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 relative’s room which was also used as a mental health assessment room.

AEC is open Monday to Friday, 08:30am to 10:30pm and has six beds and two seated areas.

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

From January 2018 to December 2018 there were 147,382 attendances at the trust’s urgent and emergency care services as indicated in the chart below.

Total number of urgent and emergency care attendances at United Lincolnshire Hospitals
NHS Trust compared to all acute trusts in England, January 2018 to December 2018

(Source: Hospital Episode Statistics)

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in 2018/19 compared to 2017/18. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from January 2018 to December 2018
During our inspection we spoke to ten patients, nine relatives, forty members of staff and reviewed twenty two patient records.
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 service provided mandatory training in most key skills including the highest level of life support training for all staff, however there was no evidence of training in dementia or mental health awareness. Completion rates were poor with only three modules out of eight achieving the trust target for nursing staff and for medical staff no modules achieved their completion rate and the completion rate for some modules was very low.

**Mandatory training completion rates**

The trust set a target of 90% for completion of mandatory training, with the exceptions of:
- Fraud awareness and infection prevention level one, which had targets of 95%.
- Local fire procedures and fire safety, which had targets of 100%.
- Immediate life support (ILS)/advanced life support (ALS) and medicine management training which had no targets. The trust informed us that the eligible numbers of staff were not available for these two courses and therefore we were unable to calculate completion rates.

We spoke to several recently recruited members of staff who confirmed that they had received mandatory training as well as that needed for their role.

According to the information we were given mandatory training did not include skills in dementia or mental health awareness training.

**Pilgrim Hospital urgent and emergency care department**

Most nursing staff received and kept up to date with their mandatory training. However, completion rates were poor with only three modules out of eight achieving the trust target for nursing staff.

A breakdown of compliance for mandatory training courses as of February 2019 for qualified nursing staff in the urgent and emergency care department at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>50</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>49</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>48</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>47</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>47</td>
</tr>
<tr>
<td>Basic life support</td>
<td>46</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>40</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>40</td>
</tr>
<tr>
<td>Information governance</td>
<td>40</td>
</tr>
<tr>
<td>Fire safety</td>
<td>37</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>34</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>30</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>20</td>
</tr>
</tbody>
</table>
These figures represented an improvement for all modules since our last inspection in February 2018.

At Pilgrim Hospital’s urgent and emergency care department, the target was met for three of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

Most medical staff received and kept up to date with their mandatory training. However overall completion rates were poor with no modules achieving the trust target for nursing staff and some medical staff had completed no mandatory training modules.

Trust data returns showed six medical staff at Pilgrim Hospital A&E had completed no mandatory training courses.

A breakdown of compliance for mandatory training courses as of February 2019 for medical staff in the urgent and emergency care department at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Information governance</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>7</td>
<td>9</td>
<td>77.8%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>7</td>
<td>9</td>
<td>77.8%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Fire safety</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Basic life support</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>5</td>
<td>9</td>
<td>55.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>4</td>
<td>9</td>
<td>44.4%</td>
<td>90.0%</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>8</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital’s urgent and emergency care department, the target was not met for any of the 11 applicable mandatory training modules for which medical staff were eligible. However, the completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates. In three cases, the completion rates of 88.9% were just below the 90% target.

These figures represented an improvement for all modules since our last inspection in February 2018.

The remaining module had no eligible staff number available and no completion target but had staff members who had completed the module.

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

The Mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

There was a clear and accurate system in place to manage the mandatory training, the trust knew who needed training figures for completion were low and for some modules very low.
There was also trust wide mandatory e-learning training for sepsis. Figures were not available for each individual emergency department but the trust overall figure was 82% which represented an improvement since our last inspection in February 2018 but did not meet the trust target of 90%

**Safeguarding**

Most staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff were provided with training on how to recognise and report abuse. Completion rates for nursing staff were mostly met, however, those for medical staff were low.

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

**Pilgrim Hospital urgent and emergency care department**

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of February 2019 for qualified nursing staff in the urgent and emergency care department at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>48</td>
<td>53</td>
<td>90.6%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>48</td>
<td>53</td>
<td>90.6%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>47</td>
<td>53</td>
<td>88.7%</td>
<td>90.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>47</td>
<td>53</td>
<td>88.7%</td>
<td>90.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>30</td>
<td>34</td>
<td>88.2%</td>
<td>90.0%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

At Pilgrim Hospital’s urgent and emergency care department, the 90% target was met for two of the five safeguarding training modules for which qualified nursing staff were eligible.

Most medical staff received training specific for their role on how to recognise and report abuse but completion rates were significantly below trust targets.

A breakdown of compliance for safeguarding training courses as of February 2019 for medical staff in the urgent and emergency care department at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

At Pilgrim Hospital’s urgent and emergency care department, the 90% target was not met for any of the five safeguarding training modules for which medical staff were eligible. Completion rates should be interpreted with care as the low number of staff will have impacted on the rates.

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

There were suitable polices, processes and systems in place to protect children and vulnerable adults from abuse and these were available to staff in the department. Safeguarding leadership
was provided by the Director of Nursing and there was access to senior staff for concerns involving children.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

The safeguarding children standards of the Royal College of Emergency Medicine (RCEM) were met and those staff who were trained were trained to an appropriate level.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff we spoke to were confident about what to do about a safeguarding concern and were able to give examples of when they had needed to report something. We spoke to a healthcare assistant and asked about any recent safeguarding incidents. She told us of a difficult situation where an adolescent had disclosed suicidal intent but had not wanted the staff member to report it. She had spent time with the young person and explained that they had a duty to do so.

The Department of Health SAFER tool was used to identify and deal with children at the risk of abuse. When we reviewed records, we noted that the tool was used but the member of staff completing it did not always sign that they had done so. However, trust audits of this for the months of April, May and June recorded that compliance for those months was variable and never met the trust target of 90%.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However recent audits provided by the trust demonstrated that there had been variable compliance with trust infection control standards in recent months.

Ward accreditation reports for May and June 2019 demonstrated that concerns had been raised about, amongst other things general cleanliness and tidiness as well as completion of checklists to assure this.

At the time of our inspection, all areas of the department were clean and had suitable furnishings which were clean and well-maintained.

Many areas had furnishings replaced since our last inspection in February 2018 and they were made of easy to clean materials. Public toilets were clean and although the sluice was small it was clean and tidy.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). However, a recent change to infection control procedures meant vomit bowls were not stored close to the point of use.

The trust had polices in place to minimise the risk of infection from the insertion of catheters trust audits demonstrated low compliance with the standards in the months leading up to the inspection.

Several members of staff told us that no vomit bowls were allowed in rooms or cubicles so if a patient was nauseous they had to fetch one from the sluice. Staff told us of instances of patients vomiting without a bowl and we were told staff had taken to hiding the bowls.

The department carried out hand hygiene audits and the most recent figure demonstrated an 87% compliance. During our visit we did not observe any staff not complying with hand hygiene or PPE requirements. We noted materials on notice boards relating to the Royal College of Nursing “glove awareness week”.
A piece of work was undertaken by the trust between January and March 2019 (quarter four) which changed the way in which hand hygiene was assessed. Prior to this the trust would receive consistent 100% hand hygiene compliance in most areas and recognised that this probably did not reflect actual practice. The trust therefore changed the hand hygiene assessment methodology to better reflect a more accurate position and to show the areas where non-compliance needed support. During quarter four, the infection prevention and control (IPC) team briefed the trust IPC committee to advise that they expected hand hygiene numbers to decline as the new assessment tool was rolled out. This guided the IPC team on where they needed to focus their efforts to support improvements.

Staff mostly cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

During our visit we observed trust policies in respect of equipment cleaning being followed. Trust audits demonstrated variable compliance with the standards in the months leading up to the inspection.

In addition to domestic staff there each day a healthcare support worker was assigned the role of cleaning equipment and restocking consumables. On several occasions we observed the isolation cubicle being appropriately cleaned after being used.

The departmental uptake for the flu vaccine over the recent winter was 88% which was well above the national target of 75%.

**Environment and equipment**

The department was too small for the number of patients it dealt with and this impacted on how patient flows could be implemented. It also resulted in patients being treated in corridors or the central space of the department and having their dignity compromised.

The department was not compliant with several standards. However, managers had thought carefully about how to best use the space and staff worked hard to minimise the effects on patients. The maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Overall the department was tidy, uncluttered and organised but despite the department operating under quite a low level of demand compared to our previous inspection all inspectors noted it to be crowded and many commented on the noise level which was often still loud even when the department was less busy.

There was a helipad located on the hospital site for use during daylight hours. At night helicopters used a local airfield and were transferred by ambulance.

Patients could reach call bells and staff responded when called.

During the inspection we noted that call bells were usually in reach of patients and they had had their attention drawn to them.

The design of the environment mostly followed national guidance but compromises were made because of space constraints. Overall the department was not compliant with Psychiatric Liaison Accreditation Network (PLAN), Intercollegiate Committee for Standards for Children and Young People in Emergency Care and Health Building Note 15-01: Accident and Emergency Departments.

The four bedded resuscitation bays were of sufficient size appropriately equipped and positioned close to the ambulance entrance and the station used by the nurse and doctor in charge. One of the bays was allocated to children and since our last inspection in February 2018 had been appropriately decorated and distraction toys were available. It was positioned so as to minimise views of adults in the other bays. However, compared to the others it contained more equipment, was thus cramped and there would be difficulty to get access behind the head of a patient.
corner of this bay was also used to store emergency transport bags and other items which added to the cramped conditions.

The three Rapid Assessment and Treatment (RAT) cubicles were of sufficient size, appropriately equipped and positioned close to the station used by the nurse and doctor in charge.

There were eight majors’ cubicles which contained a trolley. During our visit these cubicles were refurnished with comfortable chairs that allowed patients to “sit out” should they wish. The cubicles were equipped with suitable equipment and piped gases.

One of the cubicles was equipped and suitably decorated for children. Thought had been given as to where it was located out of the way of adult patients and opposite the cubicle used for infected patients which was could be used as a second children’s cubicle. This allowed one nurse to safety monitor both patients and on one occasion we saw two mothers interacting between the cubicles and giving support to one another.

However, staff told us this caused a problem taking children through from the waiting area past sick adults, they said they tried to go around the back but it was not always possible. This was typical of the many compromises and judgements that staff had to make to compensate for the patient environment.

There were three minors’ cubicles which were very small and during our visit staff appeared reluctant to put patients in there unless they had to. They were further cramped by the equipment that was in there. In addition, patients were provided with a plastic chair to sit on.

There was a “fit to sit” area that was pleasantly furnished and appropriately equipped. However, because patients were often accompanied by one or more relatives it quickly became crowded. Wall mounted suction and oxygen equipment impinged on some seats and a portable suction unit was stored balanced on a chair.

Rooms were often purposed for more than one group of patients. For example, cubicle five was used for patients with infections but also as a second children’s cubicle and the relatives room doubled as an assessment room for patients with mental health issues. This was done in a planned manner and staff all knew which rooms to use but when the department was busy staff were constantly managing the occupancy and shuffling patients around dependent on their individual needs. This resulted in a continual reprioritisation of who needed the space most and resulted in suboptimal accommodation for some patients.

There was a relative’s room that was also used a space for patients with mental health problems. While suited for use as a relative’s room it was not suitable nor safe as a mental health assessment room. When used for this purpose any relatives using the room were asked to leave, and the door was left open. However, there were blind spots, patients had access to ligature points and patients could not be kept safe from harm unless they were continually observed. The provider was aware of this and at the time of our inspection a new relative’s room was being built and the existing room would then be converted into a suitable facility.

We spoke to a young patient who frequently presented with mental health issues. They told us that they usually had to sit in the reception area when waiting for specialist psychiatric nurses to see them as there was not usually somewhere suitable in the department.

New seats had been recently installed for the A&E waiting area and they were clean and comfortable. However, eight of them could not be seen from either the reception counter nor the door of the triage room. The chairs all had arms so that people could not come in and use the reception to sleep which avoided difficult situations the nursing staff. However, this meant that none of the chairs could comfortably accommodate bariatric patients.
There was a separate children’s waiting area in reception that had a door and was well decorated and had suitable toys available. At night this was not used and was closed off by use of a metal shutter.

Staff carried out daily safety checks of specialist equipment.

We saw that there were checklists for various items of equipment and when we examined these they had been completed. We also checked resuscitation equipment against these lists ourselves on one day of our inspection and found them correct.

The service had facilities for patients’ families. However, this was in the form of a single room which was also used as a mental health assessment room.

There was a relative’s room that was also used a space for patients with mental health problems. While suited for use as a relative’s room it was not suitable nor safe as a mental health assessment room. When used for this purpose any relatives using the room were asked to leave.

The service had enough suitable equipment to help them to safely care for patients. However, equipment service labelling was confusing.

All electromedical equipment was labelled with an asset number and we were assured that they were maintained by a competent body. However, we noted a variety of labels including a green one indicating when an electrical safety test had been carried out, a blue one indicating when it had been serviced and red one indicating when a battery had last been replaced. However, without a comprehensive knowledge of equipment maintenance schedules staff could not know that equipment was safe to use. We did notice that some equipment had an orange label that indicated a “next test due” date as well as a “last serviced” date. When we talked to staff they were not aware of these labels and did not consider that it was appropriate to check that equipment was in date before being used on a patient.

Trust policy required that patients who were identified as needed a pressure mattress were required to be transferred to one within two hours. In normal hours the portering service provided this equipment within the required timescale and out of hours this was arranged by the site manager. There was a documented escalation procedure in place should there be problems.

Staff disposed of clinical waste safely.

Throughout our inspection we observed staff handling, disposing of and storing waste properly. Although small, the sluice was suitably equipped, clean and tidy.

**Assessing and responding to patient risk**

Staff did not always complete risk assessments for each patient swiftly or correctly. Identified risks were not always removed or minimised and assessments were not always updated. Staff did not always identify patients at risk of deterioration nor act quickly to respond to these patient’s circumstances.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for each 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 ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
examined later. From the time you arrived, how long did 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 (October 2016 to March 2017; published October 2017)

**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 in 10 months over the 12 month period from March 2018 to February 2019.

Performance has been improving since November 2018 and in the most recent month reported, February 2019, the median time to initial assessment was eight minutes compared to the England average of nine minutes.

**Ambulance – Time to initial assessment from March 2018 to February 2019 at United Lincolnshire Hospitals NHS Trust**

![Graph showing median time from arrival to initial assessment from March 2018 to February 2019 at United Lincolnshire Hospitals NHS Trust.

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

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

**Pilgrim Hospital**

From April 2018 to March 2019 there was no discernible trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Boston Pilgrim Hospital.

In the most recent month reported, March 2019, 70.9% of ambulance journeys had turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Boston Pilgrim Hospital**
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Boston Pilgrim 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 14 May 2018 to 10 March 2019, the trust reported 4,804 “black breaches”, with an upward trend over the period. The number of black breaches peaked in the winter months, January and February 2019.
Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However not all patients were assessed as required on admission and scores were not always applied to every observation. Some patients were not observed in line with the trusts observation policy.

The department used the National Early Warning Score 2 system (NEWS2) to score and identify deteriorating adult patients.

The department had also introduced a team of knowledgeable and experienced staff from leading children’s hospitals who were on secondment to develop skills, leadership and promote changes to systems to safely care for children. This “STRIKE Team” had worked with local staff to introduce a Paediatric Early Warning System (PEWS) in conjunction with the Paediatric Observation Priority Score (POPS).

There were protocols in place to ensure that patients requiring emergency interventions were placed on a pathway or received a package of care.

When we looked at records we found observations of patient’s vital signs were not always done in a timely manner and on two occasions we had to draw this to the attention of staff for patients in the department. This was consistent with the trusts own “Ward Accreditation” audits for the months leading up to our inspection.

We also saw good examples of staff recognising signs that a patient was unwell and responding. For example, an HCA doing observations was told by patient that pain had moved to their back and become more severe in some positions. They immediately went to an RN and described the situation in detail who in turn escalated to a doctor who went to a patient. They were satisfied and increased the patients pain relief.

For adult patients the trust policy required that the early warning scoring system was used during the initial assessment process. Trust audits that we saw should that in the months leading up to our inspection compliance with this was variable and sometimes low. For example, one audit report for the month of May reported the NEWS2 was only recorded 6 times out of 14.

For children they were initially assessed at triage and then reassessed using the POPS system. Should a child score greater than 8 on the POPS system they were transferred to the

* Please note that May 2018 and March 2019 are partial months.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)
resuscitation area and PEWS scoring started. This meant that for a child who had deteriorated their baseline PEWS score was when they had already become sick and for other children transferred to the ward their baseline PEWS score was on the ward. However, POPS scoring was used by the local NHS ambulance service which meant a longitudinal record was available for conveyed patients prior to arriving in the hospital.

We observed very few children attend A&E during our inspection but trust audit reports that we were sent noted that this system was not yet full embedded with one stating “Still appears to be inconsistent recording of POPS [sic] Physiological obs not always taken in line with POPS [sic] requirements. Recorded in the Patient record 2/6 times”

However, the system was still being introduced and at the at the time of our inspection, 20 of the 32 registered staff required training. We saw an appetite from staff to complete their training as, when we were interviewing the staff who delivered this training, they were being interrupted by staff trying to arrange it.

A full audit of the effectiveness of the system had been started the week prior to our inspection visit and as such no data was yet available.

Staff were overwhelmingly positive about the introduction of POPS. One Health Care Assistant (HCA) told us that the POPS training had been very good and as an HCA it gave them confidence to identify and report a deteriorating child.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. Staff knew about and dealt with any specific risk issues. However they were not always completed or acted on. In the case of sepsis screening there were omissions of screening and treatment which put patients at significant risk of avoidable harm.

There were risk assessment tools in place to cover risks such as falls, pressure damage and deep vein thrombosis. There were education boards in place in staff areas covering particular current topics of risk including sepsis, Diabetic Ketoacidosis (DKA), aortic aneurysm and pressure sores.

Proformas for the Rapid Assessment and Treatment (RAT) process were both appropriate and easy to use. The Rat area was well managed with allocated staff but despite not being put to the test by capacity during out visit it was evident that response to patient’s assessments from some staff was slow.

When we looked at records we saw that there was inconsistency in application of the risk assessments. We saw records that were completed to a very good standard but others which were poor. We saw one record where despite a good initial assessment, no other assessments were recorded for the whole of their stay in the department.

There was a safety checklist in place but this was used inconsistently and we also noted a simplified version in use alongside it.

We spoke to the sepsis champion who explained that they reviewed notes electronically, checked why actions were not done and escalated as needed. They sent all missed sepsis screens to the trust sepsis practitioner who identified trends and spoke with individual staff.

Due to the quality of this data we identified significant concerns about sepsis. Data showed at Pilgrim Hospital, on the 11 June 2019, three out of seven patients had a NEWS of five or more, indicating in line with the Trust sepsis policy they would need to have a sepsis screen completed. None of the three patients had a sepsis screen completed. This posed significant risk of avoidable harm to patients and the trust policy on managing sepsis was not complied with.
Data showed at Pilgrim Hospital on 12 June 2019, three out of 15 patients had a NEWS score of 5 or more indicating in line with the Trust sepsis policy they would need to have a sepsis screen completed. Of the three patients, two did not receive a sepsis screen and one patient received a screen at 150 minutes. The patient screened for sepsis at 150 minutes was positive for sepsis and received antibiotics at 95 minutes versus a 60-minute standard. This posed significant risk of avoidable harm to patients as this was not in line with national guidance or trust policy. National guidance states patients should receive antibiotics within an hour of the sepsis trigger being identified.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health)

Staff told us that referrals to psychiatric liaison services were triggered by self-reporting of mental health needs by patients. Risk assessments were done at triage and staff told us they would prioritise patients with mental health issues through into triage. Support was offered based on risk and need while waiting for the psychiatric liaison nurses to attend. This ranged from checking on them to sitting and talking on a one to one basis which was usually done by healthcare assistants.

Staff commented positively on the support that the psychiatric liaison nurses provided. We were also told by a young patient who was a frequent visitor to the department with their mental health issues that the mental health specialists were always of help.

Although there was a process in place staff did not always completed psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

When asked whether any specialist assessment tools for patients at risk of self-harm were used staff told us they were not aware of them.

We looked at nine sets of records for patients who had been identified as having mental health issues. Some of these sets of records recorded the patients attending one several occasions. In none of the nine records was there a mental health form. In seven of the sets of records there was no form of mental health risk assessment recorded.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe.

We noted that medical handover in the department took place at 8am and 3pm as different staff came on shift in line with their rotas.

Nursing staff had a handover in the reception office at the start of each shift and we observed this to be well attended and managed. We noted that a flipchart was used to record key messages for the shift and left in place so that the information was always available.

Individuals were allocated to specific roles or areas. There was a talk through of the situation in the department and delays to specific patient’s progress was discussed. We saw staff reminded about handwashing, gloves, aprons, SAFETY hourly rounding, pain and oxygen bands. Reference was also made to lessons learnt from the month of May and we understood this was done on all handovers so that no one failed to hear the message.

Every two hours the nurse in charge and the Emergency Practitioner in Charge (EPIC) had a “safety huddle”. We also saw this done as patient flow or capacity became a challenge. These “huddles” were documented and kept in a file.

Paediatric patients causing concern including all who had triggered a PEWS assessment were discussed every two hours with the children’s ward. Nursing staff confirmed that this two hourly call was useful, always took place when needed and that the children’s ward was supportive.

**Nurse staffing**

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to keep patient’s safe from avoidable harm and to provide the right care and treatment relying on substantial numbers of bank and agency staff.
However, managers continually reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

In the following analysis of nursing staff, please note that low numbers of staff in some teams will have impacted on the rates. Therefore, these should be interpreted with care.

**Pilgrim Hospital**

The number of nurses and healthcare assistants on all shifts on each ward did not always match the planned numbers.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. However, in order to do this, they needed to make use of significant numbers of bank and agency staff.

An experienced nurse in a substantive post told us that planning for skill mix was difficult because of high number of agency staff. Another nurse told us that this meant because of their specific skills they were always allocated to the same area meaning they had little opportunity for professional development and that they often got bored.

The service did not meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children’s nurses on each shift. With the support of a team of knowledgeable and experienced staff from leading children’s hospitals who were on secondment to develop skills, leadership and promote changes the department was developing certain adult nurses to develop paediatric competences and good progress was seen on this.

The managers could adjust staffing levels daily according to the needs of patients and predicted demand. However, their ability to do this was restricted by the low numbers of permanent staff and the need to use bank and agency staff.

The service did not have enough nursing staff of all grades to keep patients safe.

The service had high vacancy rates.

The trust had a permanent rolling advertisement for staff in the department. The band seven establishment was fully staffed but band six nurses were below establishment by 5 members of staff and the band five establishment was below by 29. The trust ensured as many band five staff were on duty as possible by paying bank shifts for band five nurses at the mid-point of band six.

Pilgrim Hospital reported the following WTE nursing staff numbers for the periods below for urgent and emergency care.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Integrated assessment centre</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>A&amp;E Pilgrim</td>
<td>32.8</td>
<td>42.1</td>
</tr>
<tr>
<td>A&amp;E acute care practitioner team</td>
<td>9.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Ambulatory care</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Acute medical unit</td>
<td>20.0</td>
<td>28.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>69.8</strong></td>
<td><strong>88.6</strong></td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the nursing staffing rate within urgent and emergency care at Pilgrim Hospital was 78.8%. This was higher than the rate of 64.4% in the more recent period from April 2018 to February 2019.

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

Pilgrim Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Pilgrim</td>
<td>40.9%</td>
</tr>
<tr>
<td>A&amp;E acute care practitioner team</td>
<td>35.1%</td>
</tr>
<tr>
<td>Acute medical unit</td>
<td>35.1%</td>
</tr>
<tr>
<td>Ambulatory care</td>
<td>31.3%</td>
</tr>
<tr>
<td>Integrated assessment centre</td>
<td>18.4%</td>
</tr>
</tbody>
</table>

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

Turnover rates

Pilgrim Hospital

The service had high turnover rates,

Two of the five departments had turnover reported from April 2018 to March 2019

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E acute care practitioner team</td>
<td>30.1%</td>
</tr>
<tr>
<td>A&amp;E Pilgrim</td>
<td>10.4%</td>
</tr>
</tbody>
</table>

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

Sickness rates

The service had high sickness rates.

Pilgrim Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory care</td>
<td>21.9%</td>
</tr>
<tr>
<td>A&amp;E acute care practitioner team</td>
<td>14.4%</td>
</tr>
<tr>
<td>A&amp;E Pilgrim</td>
<td>10.2%</td>
</tr>
<tr>
<td>Integrated assessment centre</td>
<td>9.3%</td>
</tr>
<tr>
<td>Acute medical unit</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

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

Bank and agency staff usage

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

We spoke to two agency nurses about this. One been working only in A&E at Pilgrim for one and a half years, the other only a week. Both reported that they were welcomed, part of the team and had received a proper induction. They told us their services were block booked by the hospital with the agency that supplied them.

Pilgrim Hospital

The tables below show the numbers and percentages of nursing hours in urgent and emergency care at Pilgrim Hospital from March 2018 to February 2019 that were covered by bank and
agency staff or left unfilled.

**Qualified nursing staff**
The service had high rates of bank and agency nurses used in the department.

Of the 132,511 total working hours available, 7.3% were filled by bank staff and 36.4% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 6.4% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2018 to February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
<td>Bank usage</td>
<td>Agency usage</td>
<td>Not filled by bank or agency</td>
</tr>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Integrated assessment centre (IAC)</td>
<td>33,216</td>
<td>1,071</td>
<td>3.2%</td>
<td>7,417</td>
</tr>
<tr>
<td>A&amp;E nursing</td>
<td>99,295</td>
<td>8,582</td>
<td>8.6%</td>
<td>40,878</td>
</tr>
<tr>
<td>Total</td>
<td>132,511</td>
<td>9,653</td>
<td>7.3%</td>
<td>48,295</td>
</tr>
</tbody>
</table>

**Non-qualified nursing staff**

Of the 73,255 total working hours available, 32.6% were filled by bank staff and 6.8% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 23.3% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2018 to February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
<td>Bank usage</td>
<td>Agency usage</td>
<td>Not filled by bank or agency</td>
</tr>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Integrated assessment centre (IAC)</td>
<td>18,537</td>
<td>3,616</td>
<td>19.5%</td>
<td>332</td>
</tr>
<tr>
<td>A&amp;E nursing</td>
<td>54,718</td>
<td>20,296</td>
<td>37.1%</td>
<td>4,657</td>
</tr>
<tr>
<td>Total</td>
<td>73,255</td>
<td>23,912</td>
<td>32.6%</td>
<td>4,989</td>
</tr>
</tbody>
</table>

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

**Medical staffing**

The service did not have enough permanently employed medical staff with the right qualifications, skills, training and experience to keep patient’s safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed staffing levels and skill mix, recruited sufficient locum doctors and gave those locum staff a full induction.

**Trust level**

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for urgent and emergency care.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td></td>
<td>13.0</td>
<td>15.0</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Grantham and District</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>17.4</td>
<td>33.2</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>18.0</td>
<td>30.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48.4</strong></td>
<td><strong>78.2</strong></td>
</tr>
</tbody>
</table>

The medical staff did not match the planned number on all shifts in the department. From April 2017 to March 2018, the overall medical staffing rate within urgent and emergency care was 61.9%. This was higher than the rate of 52.7% in the more recent period from April 2018 to February 2019. This is primarily due to the number of planned staff increasing while the actual number of staff in post remained similar.

As there was only one team based at each of the sites being inspected, Lincoln County Hospital and Pilgrim Hospital, these are represented in the site breakdown above.

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

**Vacancy rates**

The service did not have enough medical staff on permanent contracts to keep patients safe. However, they demonstrated an innovative approach to the recruitment of consultant and middle grade doctors as well as ensuring shifts were covered by locums.

The service had high vacancy rates for medical staff which had worsened since our last inspection. However, this was due to an increase in the number of posts rather than a loss of staff.

**Trust level**

From April 2018 to March 2019, the trust reported a vacancy rate of 46.4% for medical staff in urgent and emergency care. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital urgent and emergency care department: 51.3%
- Pilgrim Hospital urgent and emergency care department: 54.8%

Both sites just had the one department reporting vacancies. These are detailed above.

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

**Turnover rates**

The service had much higher turnover rates for medical staff, four times the trust target.

**Trust level**

From April 2018 to March 2019, the trust reported a turnover rate of 31.9% for medical staff in urgent and emergency care. This was higher than the trust target of 8%. Turnover data for medical staff includes trainee grades which may have inflated the rate.

- Lincoln County Hospital urgent and emergency care department: 37.1%
- Pilgrim Hospital urgent and emergency care department: 31.3%

Both sites just had the one department reporting turnover. These are detailed above.

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

**Sickness rates**
Trust level

Sickness rates for medical staff were low.

From April 2018 to March 2019, the trust reported a sickness rate of 3.3% for medical staff in urgent and emergency care. This was lower than the trust target of 4.5%.

- Lincoln County Hospital urgent and emergency care department: 5.5%
- Pilgrim Hospital urgent and emergency care department: 1.6%

Both sites just had the one department reporting sickness. These are detailed above.

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

Bank and locum staff usage

The service had high rates of bank and locum staff used in the department but managers could access the locums they needed when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

All consultant level locum staff were required to have membership of the Royal College of Emergency Medicine.

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service told us that there had been an improvement in non-covered shifts. We requested rotas that covered all staff grades for the months leading up to our inspection and we noted that shifts were rarely not covered by doctors with suitable skills. This was achieved only with a great deal of effort on the part of managers and administrators as well as flexibility and commitment on the part of the doctors. We saw that detailed forward planning took place that accounted for bank holidays and such like well in advance. We understood that the introduction of a single rota for all medical staff grades had made this easier to manage.

We also noted that the presence of medical staff with suitable levels of competence in looking after sick children which had been a significant concern at our last inspection had improved greatly. We requested and saw evidence that this was the case on almost every shift in the four months leading up to our inspection.

In January 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 50 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>28%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career</td>
<td>28%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>14%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>30%</td>
<td>21%</td>
</tr>
</tbody>
</table>
The service always had a consultant on call during evenings and weekends. The department ran a variety of shifts across the various staff grades and handovers took place between doctors at these changeover times. The consultant level Emergency Practitioner in Charge (EPIC) was always on duty on the day and evening shifts from 8am to 11pm. This was one hour a day less than the Royal College of Emergency Medicine (RCEM) recommendation of sixteen hours a day. Between 10:30pm to 8:30am the trust required the most senior doctor in the department to be at least a Specialty Trainee of level four, (ST4+), who was from an approved list of doctors familiar with the department, its policies and procedures. There was always a named consultant on call and middle grade staff told us they had good access to advice out of hours. These arrangements were established in an “EPIC Standard Operating Procedure”.

Only one consultant was employed in a substantive post, all the others being locums and this doctor was the only one on the specialist register. However, the trust through the efforts of a group of staff including a consultant doctor responsible for the Certificate of Eligibility for Specialist Registration (CESR), had put a deal of effort into recruiting consultant staff doctors into substantive posts. We saw good evidence that they would achieve their target of having suitable staff in post and working towards the specialist register by September 2019. This was part of a strategy to attract senior staff through training opportunities to avoid the recruiting difficulties associated with the county.

Records

Staff kept detailed records of patients’ care and treatment. Records were usually clear, up-to-date and easily available to all staff providing care. However, we did see examples of poor and incomplete record keeping particularly in respect of mental health assessments. Patient notes were usually comprehensive and all staff could access them easily. However, we did see examples of poor and incomplete recordkeeping.

We looked at 22 patient records during our inspection and we saw most records were completed to a good standard. For example, in the case of a patient admitted on 6 June at 1:22am we saw risk assessments and the SAFER tool completed, the drug chart was completed appropriately and there was good evidence of care rounding. All entries in the record were signed and dated. Similarly, for another patient admitted on the same day who went through the Rapid Assessment and Treatment (RAT) process, the RAT documents were completed to a good standard.

However, for another patient we saw admitted during the early morning there was a very good completion of the record for their first hour in the department, but then rounding records were not completed again before discharge at 3:35pm. The SAFER tool was done at noon but not signed.
We also saw that safety checklists and rounding documents were inconsistently used. There were simplified versions of these documents that were used as well as the established version.

We looked at nine sets of records for patients who had been identified as having mental health issues. Some of these sets of records recorded the patients attending on several occasions. In none of the nine records was there a mental health form. In seven of the sets of records there was no form of mental health risk assessment recorded.

When reviewing notes, we noted a patient admitted at 9:54pm the previous day who had a CT scan but for whom the result was not yet on the system three hours later. We were told that this was because the reading of the scans was outsourced. Record keeping for this patient was good and the medical plan appropriate.

There were other instances of very good medical notes. However, in the case of a patient admitted on 9 June we saw there was no examination note by the doctor. We escalated this to the nurse in charge who discussed this issue with the EPIC to remind doctors of the importance of documentation.

When patients transferred to a new team, there were no delays in staff accessing their records. All patients were recorded on an Electronic Patient Record (EPR) system which recorded where the patient was, clinical data including observations and pathology results. Key information, including early warning scores were displayed on a central electronic board. This information was noted as being kept up to date and formed the basis of the safety huddles, staff deployment and flow discussion in the department.

Records were stored securely.

We noted that the reception area where records were stored was secure, well organised and despite the space constraints tidy and not cluttered. Reception staff worked well with clinical staff particularly the member of staff allocated to the Pre Hospital Assessment role to prepare casualty cards ready for expected ambulances and again with the ambulance crews on arrival.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines. However, there were occasions when controlled stationary was improperly stored and the Patient Group Directives (PGD) for the department were out of date and were not being used.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff followed current national practice to check patients had the correct medicines.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines.

While in the department we observed the administration of medicines and looked at records and drug charts. We saw records and charts were completed correctly and the required checks were made during the administration of medicines.

Patient Group Directives were out of date by two years and so were not being used which resulted in some patients not getting analgesia in a timely manner.

We noted a trust wide system of coloured wristbands that identified an oxygenation target was in place to ensure that patients prescribed oxygen could be easily identified and were on an effective correct dose. We saw that this was carried out inconsistently in the department and that the absence of a band could not be relied on as an indication that the patient was not prescribed oxygen. We spoke to the respiratory nurse specialist who said that they were aware of the
problems of compliance and that they considered it a staffing issue as it was difficult to implement change with temporary staff. However, we noted on the evening handover we observed that the nurse in charge referred to this requirement in their briefing.

Staff stored and managed all medicines in line with the provider’s policy. However, we saw two examples of when prescribing documents were not properly stored.

On one occasion we saw that controlled stationery was lying unattended on a worktop and we also noted that it was stored in an insecure drawer in Majors. This was drawn to the attention of the nurse in charge who immediately removed them.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

We noted that the medicines fridge in the resuscitation area had been outside of temperature in June 2019 and staff told us that it had been reported but were not sure what actions had been taken. We considered that this should have been reported as an adverse incident and when we asked for the relevant record the trust was able to demonstrate that the medicines had been disposed of and that the liaison pharmacist provided ad-hoc training in the department.

Decision making processes were in place to ensure patient’s behaviour was not controlled by excessive and inappropriate use of medicines.

We saw policies in place for the appropriate use of sedatives.

Incidents

The service had systems to manage patient safety incidents. Staff recognised incidents and near misses, reported them appropriately and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, managers had not investigated incidents in a timely manner and there was a backlog.

Never Events

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

From March 2018 to February 2019, the trust reported one never event for urgent and emergency care. This serious incident, which occurred in May 2018, related to the mis-selection of high strength midazolam during conscious sedation. It was classified as a medication incident meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 39 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from March 2018 to February 2019.

Pilgrim Hospital

In accordance with the Serious Incident Framework 2015, Pilgrim Hospital reported 22 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from March 2018 to February 2019.
<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>8</td>
<td>36.4%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including</td>
<td>6</td>
<td>27.3%</td>
</tr>
<tr>
<td>failure to act on test results)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>6</td>
<td>27.3%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>1</td>
<td>4.5%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
<td>4.5%</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff knew what incidents to report and how to report them, staff reported incidents that they should report and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

When we discussed adverse incidents with staff they knew how to report them and were able to give examples of when they had done so. They also spoke of the duty of candour and were able to articulate what was expected of them by the trust.

We discussed recent incidents and any learning that had taken place with senior nursing staff. They told us of an incident when an agency nurse had mislaid notes for bloods leading to a missed glucose result and a delayed diagnosis for the patient. They also demonstrated how learning was shared across sites by showing how an incident resulting in Diabetic Keto Acidosis in A&E at Lincoln was disseminated at the A&E at Pilgrim.

Managers had not investigated incidents in a timely manner.

We were concerned that there had been a backlog of more than 1000 open incidents on the trust’s incident reporting system that had not been reviewed. We saw that this was being addressed through a programme of work and that time was set aside each week to do this. At the time of our inspection 300 had been addressed.

Staff received feedback from investigation of incidents, both internal and external to the service.

Managers shared learning with their staff about never events that happened elsewhere.

We saw information on notice boards about learning from serious incidents internal to the trust and also for incidents elsewhere that had been disseminated through national system. When we attended nursing handovers learning from recent incidents was included in the handover and recorded on the flipchart used during the briefing.

Safety thermometer

The service monitored key safety thermometer indicators. However, it did not display the data nor use it to improve safety.

The service did not display or use the key safety thermometer information that it collected from its monitoring

Safety thermometer data was not displayed in the department for staff and patients to see.

Although safety thermometer information was provided to us following our information request it was not displayed in the department.

There was no evidence that staff used the safety thermometer data to further improve services.

Staff were not aware of the safety thermometer results nor of any actions resulting from them.
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 no new pressure ulcers, four falls with harm and one new urinary tract infection in a patient with a catheter from March 2018 to March 2019 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of falls and catheter urinary tract infections at United Lincolnshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Total falls (4)</th>
<th>Total CUTIs (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Falls with harm levels 3 to 6</td>
<td>3 Catheter acquired urinary tract infection level 3 only</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - Safety Thermometer)

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. However, staff did not demonstrate sufficient knowledge to protect the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance.

Treatment and care was based on national guidance and standards including that from the National Institute for Health and Care Excellence (NICE) and the Royal college of Emergency Medicine (RCEM)

These were delivered through the use of care pathways and treatment bundles covering for example, fractured neck of femur and sepsis. We noted that since our last inspection a frailty pathway had been introduced and was working to good effect.
There were local audits in place, for example covering adherence to sepsis guidelines and these were used effectively to identify issues in the delivery of care. However, engagement with audits by the Royal college of Emergency Medicines, as noted in our previous inspection was low as there was limited resource for senior medical staff to complete them.

We observed a low acuity, adult, trauma call from a road traffic collision. Although tabards were not worn members of the team and their roles were identified. The nurse in charge was overseeing the nurses and at one stage told staff to pay attention to the handover from the ambulance crew. The process was calm, structured and followed the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) principals. There was good communication including with the patient.

We observed a second resuscitation where there was a delay of ten minutes between the patient arriving in the resuscitation area at 10:05am and the first observation taking place. The patient’s oxygen saturation was recorded at 10:15am, blood pressure at 10:17am and the observations were only documented at 10:19am. Only one nurse was present to carry out the observations but during this time five doctors were present who did not have an allocated activity.

In a third priority call the patient received good assessment and treatment.

Staff did not have enough knowledge to protect the rights of patients subject to the Mental Health Act and follow the Code of Practice.

Staff told us that referrals to psychiatric liaison services were triggered by self-reporting of mental health needs by patients. Risk assessments were done at triage and staff told us they would prioritise patients with mental health issues through into triage. Support was offered based on risk and need while waiting for the psychiatric liaison nurses to attend. This ranged from checking on them to sitting and talking on a one to one basis which was usually done by healthcare assistants.

We spoke to a young patient who suffered from poor mental health and who had visited the department on several previous occasions. They told us that although they were known to the mental health trust and registered with a GP they were not able to access these services when they needed them. They therefore accessed them through the emergency department by self-harming. They told us that the staff were always kind and supportive but did not understand their needs.

When we spoke to some staff about education they might have had regarding mental health aspects of dementia, learning disabilities and autism they told us that they had had “very little” but they were aware that additional training was planned.

They also said that that while they had received Mental Capacity Act and safeguarding training their understanding of the Mental Health Act was “poor” and they were not aware of how the act was used and what support was available for patients detained under the act.

They were also unsure about Mental Capacity Act policies and how consent would be obtained for people with impaired capacity.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

When we observed handovers of patients both for nursing staff at shift changes and during discussions led by the EPIC and senior nurses we noted that the individual needs of patients were referred to and discussed.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary.

**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 (October 2016 to March 2017; published October 2017)

Staff usually made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

The department made arrangements for patients and people with them to receive suitable food and drink. There was a small kitchen where staff could prepare food and drink for patients and since our last inspection the department had introduced a “refreshments round” which assessed patient’s need and provided drinks and high quality sandwiches. Several patients and relatives commented favourably on having been given a welcome hot drink and or sandwich without having to ask.

There was provision for patients to help themselves to a cold drink from a serving area that was clean and well stocked. The hospital had several cafés and restaurants open to visitors and there were vending machines available out of hours.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff recorded food and drink that patients had received. We saw some records where fluid balance charts had been requested by medical staff and these had been completed adequately.

**Pain relief**

Staff did not always fully and consistently assess and monitor patients regularly to see if they were in pain. Because of out of date documents and inconsistent practice some patients waited too long in pain before receiving medicines. However, when pain relief was given it was administered and recorded properly.

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.

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.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Staff did not always fully or consistently assess and reassess patients’ pain They did not always give pain relief when needed.

Trust policies required that had their pain assessed and pain scores were required to be checked and documented hourly on a checklist.

However patient records we saw showed this was not always done fully or consistently. These observations were consistent with the trust’s ward accreditation audits where we noted for June 2019 pain documentation was rated 100% while for the previous month it was 50%. We also noted that these audits recorded that for the months of March, May and June for which records were provided the audits showed that the department did not meet the required standard for pain assessment on arrival for adults and subsequent checks.

For children while the standard was met for pain assessment within 20 minutes and subsequently receiving pain relief in June it was not met in May. The requirement for Children’s pain to be
regularly reassessed was not met in either May or June. We also noted that the department submitted thirty records to the RCEM “Pain in Children” audit 2017/18. The audit found that no records met the fundamental standard of assessing children’s pain within 15 minutes. This audit also showed that while patients in severe pain had their needs met those in moderate pain did not.

While the department made use of a pain assessment tool for “non-verbal” patients we noted the trust’s ward accreditation audits for March, May and June noted use of this in the department did not meet the trust’s standard.

We did see good examples of staff recognising signs that a patient was in pain and responding. For example, an HCA doing observations was told by patient that pain had moved to their back and become more severe in some positions. They immediately went to an RN and described the situation in detail who in turn escalated to a doctor who went to a patient. They were satisfied and increased the patients pain relief.

Patients did not always receive pain relief soon after requesting it because of out of date documents and inconsistent practice.

Because Patient Group Directives (PGDs) were out of date and therefore not being used some patients were not getting analgesia in a timely manner. This was a particular problem when patients were triaged in A&E and then transferred immediately to the Ambulatory Care Unit (ACU) where doctors were not immediately available to prescribe. During our inspection we noted a patient who had been waiting in considerable pain in the ACU for three and a half hours and we had to intervene to ensure that they received pain relief.

Not all patients were receiving pain relief in a timely fashion. For example, we saw a patient arriving at 12:14pm, had their pain assessed during triage at 12:30pm, was prescribed pain relief at 12:40pm and given it at 12:46pm. In another case we saw from notes that a patient in severe pain was prescribe pain relief at 5:15pm but did not get it until 6:30pm.

Staff prescribed, administered and recorded all pain relief accurately.

Where pain relief was prescribed and administered our observations and the records we saw demonstrated that this was done correctly and accurately.

**Patient outcomes**

The service did not participate in all relevant national clinical audits. In those that it did participate performance was variable across the standards. Information from the audits was not used to improve care and treatment.

Managers did not carry out a comprehensive audit programme.

Managers did not use information from the audits to improve care and treatment.

Managers did not share and make sure staff understood information from the audits and Improvement was not checked and monitored.

We did not receive assurance that results from national audits was being used effectively to improve outcomes for patients. Some senior medical staff demonstrated little knowledge of the Royal College of Emergency Medicine audit program and we could not access any documentation to show any improvements that may have been made.

**RCEM Audit: Moderate and acute severe asthma 2016/17**

**Pilgrim Hospital**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Pilgrim Hospital’s emergency department failed to meet any of the national
The department was in the upper UK quartile for two standards:

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 44.0%; UK: 26%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 64.0%; UK: 25%.

The department was in the lower UK quartile for three standards:

- Standard 1a (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 12.0%; UK: 19%.
- Standard 5 (fundamental): If not already given before arrival to the emergency department, 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
- Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 0.0%; UK: 19%.
- Standard 5b (fundamental): within 4 hours (moderate). This department: 0.0%; UK: 28%.

The department’s results for the remaining two standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Pilgrim Hospital

In the 2016/17 Consultant sign-off audit, Pilgrim Hospital’s emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for two standards:

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 21.4%; UK: 8%.
- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 29.3%; UK: 10%.

The department’s results for the remaining two standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Pilgrim Hospital

In the 2016/17 Severe sepsis and septic shock audit, Pilgrim Hospital emergency department failed to meet any of the national standards.
The department was in the lower UK quartile for five standards:

- **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. This department: 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. This department: 1.4%; UK: 30.4%.
- **Standard 4**: Serum lactate measured within one hour of arrival. This department: 29.4%; UK: 60.0%.
- **Standard 5**: Blood cultures obtained within one hour of arrival. This department: 2.2%; UK: 44.9%.
- **Standard 8**: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 2.2%; UK: 18.4%.

The department’s results for the remaining three standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

**Trauma Audit and Research Network (TARN)**

**Pilgrim Hospital**

The table below summarises Pilgrim Hospital’s performance in the 2016 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Ascertainment</strong> (Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</td>
<td>100+%</td>
<td>Good</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury</strong> (Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</td>
<td>83 mins</td>
<td>Takes longer than the TARN aggregate</td>
<td>✗</td>
</tr>
<tr>
<td><strong>Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury</strong> (Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</td>
<td>0.0%</td>
<td>Lower than the TARN aggregate</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care *(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)*

<table>
<thead>
<tr>
<th></th>
<th>Lower than the TARN aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>

Risk-adjusted in-hospital survival rate following injury *(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)*

<table>
<thead>
<tr>
<th></th>
<th>Similar to expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4 additional survivors</td>
<td></td>
</tr>
</tbody>
</table>

(Source: TARN)

Unplanned re-attendance rate within seven days

The service had a lower than expected risk of re-attendance than the England average. However, this was higher than the expected standard.

From March 2018 to February 2019, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5%. The trust’s performance was better than the England average for eight of the 12 months reported and similar for the remaining four months.

Unplanned re-attendance rate within seven days - United Lincolnshire Hospitals NHS Trust

![Graph showing unplanned re-attendance rate over time](image)

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

Competent staff

The service made sure staff were competent for their roles. Managers appraised medical staff’s work performance and held supervision meetings with them to provide support and development. However, supervision rates for nursing staff were very low.
Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. However, because of recruitment issues and high use of agency staff there were not always sufficient numbers of staff with the right skills and experience to be deployed.

Managers gave all new staff a full induction tailored to their role before they started work. When we spoke to recently recruited staff, including those from agencies, they all told us that they had received an induction. We saw records to confirm this.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. However, appraisal rates for this staff group was very low.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

There were enough clinical educators to support staff learning and development.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend.

We saw communication books and information folders used to allow both medical and nursing staff to access information about meetings that they had not attended. Key points from these meetings were covered at each nursing handover and written on flipchart that was kept visible in the area used for handovers.

Managers identified poor staff performance promptly and supported staff to improve.

We saw evidence that some staff who were not willing to embrace the improving ethos and culture to improve standards within the department had left since our last inspection.

Managers recruited, trained and supported volunteers to support patients in the service.

Volunteers in the department supported staff through housekeeping and restocking duties. They were proud to work as part of the team and valued by other staff.

**Appraisal rates**

**Pilgrim Hospital**

From April 2018 to February 2019, 66.6% of staff within urgent and emergency care department at Pilgrim Hospital received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified ambulance service staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>26</td>
<td>40</td>
<td>65.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>30</td>
<td>50</td>
<td>60.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients.
Staff told us that relationships between staff in the department had significantly improved since our last inspection. We observed medical and nursing staff working well together with appropriate challenge when necessary.

Where new arrangements for multidisciplinary working had been introduced such as the frailty pathway we saw through observation, looking at records and talking to staff that this was working well.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

We also saw that there was improved support from the rest of the hospital to get patients moving out of A&E into specialist wards and support safety. Doctors from the children’s ward held regular telephone conversations about sick children and we noted doctors from the medical wards present in A&E to help assess patients and get them onto the wards.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Staff told us that referrals to psychiatric liaison services were triggered by self-reporting of mental health needs by patients. Risk assessments were done at triage and staff told us they would prioritise patients with mental health issues through into triage.

Staff commented positively on the support that the psychiatric liaison nurses provided. We were also told by a young patient who was a frequent visitor to the department with their mental health issues that they were always referred to mental health specialists.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services 24 hours a day, seven days a week.

The main emergency department was open 24 hours a day, every day of the year with the Ambulatory Care Unit (ACU) open between 8:30am and 10:30pm Monday to Friday.

There was suitable support from diagnostic services elsewhere in the hospital such as pathology, and radiology including Computerised Tomography (CT) to support the provision of care in the emergency department.

Some imaging was available in the department including plain film x-ray and ultrasound. We also noted that near patient testing provision had been improved in the department since our last inspection with two point of care testing machines having been introduced. Staff were very pleased with this as the additional blood tests they supported were useful as markers for patients with sepsis.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The department had relevant information promoting healthy lifestyles.

There was a wide variety of material in the department mainly in the form of material on noticeboards. This covered not just health topics but social care, counter terrorism and people vulnerable to exploitation through trafficking or modern slavery.

Information targeted at parents was good and covered the dangers associated with small batteries, online safety, passive smoking and Sudden Infant Death Syndrome (SIDS). Some of this material was in the four most common languages spoken in the area.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.
Health promotion was 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.

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

Staff did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health and did not always follow national guidance to gain patients’ consent. However, staff did support patients to make informed decisions about their care and treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions, however they did not always understand how and when to assess whether a patient had the capacity to make decisions about their care.

When we spoke to some nursing staff they said that that while they had received Mental Capacity Act training they were unsure about Mental Capacity Act policies and how consent would be obtained for people with impaired capacity.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients’ records.

Mental Capacity Act and Deprivation of Liberty training completion

Nursing staff training on the Mental Capacity Act and Deprivation of Liberty Safeguards met trust targets.

Most clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards but this was well below the trust target.

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The MCA training delivered covers all levels required and DoLS training is included in the same session so is not reported separately.

Pilgrim Hospital

A breakdown of compliance for MCA/DoLS training courses as of February 2019 at Pilgrim Hospital for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>50</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was met the MCA/DoLS training module for which...
qualified nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training course as of February 2019 at Pilgrim Hospital for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>6</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was not met for the MCA/DoLS training module for which medical staff were eligible. However, the completion rate should be interpreted with care as the low number of staff will have impacted on the rate.

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

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they did not always know who to contact for advice. Not all staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

When we spoke to some nursing staff they said that that while they had received Mental Capacity Act training they were unsure about Mental Capacity Act policies and how consent would be obtained for people with impaired capacity.

Managers did not monitor the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them nor monitor how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. However, the crowded nature of the department resulted in some conversations taking place with other patients present.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. However, during our observations of care we noted a very small number of staff who did not interact well with patients.

We spoke to ten patients and seven relatives during our inspection of the emergency department. All told us that they had been treated well and with kindness. When we observed care and treatment being given we noted this almost always to be the case.

In one case however, when we needed to draw the distress of a patient to the attention of staff, one senior staff member was notably disinterested in the patient’s experience only wishing to provide an explanation. In another a staff member supplied by an agency carried out their duties with little interaction with their patients. In contrast on a following shift a member of agency staff carrying out the same role was exemplary in the way they interacted with their patients.

Staff followed policy to keep patient care and treatment confidential. However, the crowded nature of the department resulted in some conversations taking place with other patients present. Despite this some staff were passionate about protecting their patient’s dignity and privacy and made a significant effort to do so.
On several occasions we observed medical staff talking to patients in the “fit to sit” area where they were easily overheard by adjacent patients. The conversations were kind and appropriate but not private. In contrast we saw other staff taking patients out of this area to have a discrete conversation in quiet area.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

During our inspection we spoke to two patients with mental health needs. Both had been treated with understanding and one of the patients who visited the department frequently, told us staff were always kind.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

**Friends and Family test performance**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was consistently worse than the England average from March 2018 to February 2019.

In the most recent month reported, February 2019, the trust performance was 79.0% compared to the England average of 85.3%.

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

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.
Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

During our inspection we observed patients and relatives being given the emotional support that they needed while in the department. Staff were noted to be empathic and aware of the circumstances of their patients, carers and relatives.

For patients who were cared for temporarily in a corridor area one staff member was noted to explain to all patients why they were there and how long they would be there. They recognised that one patient became confused by the environment and returned to them, several times, between other patients to explain again and reassure.

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

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment.

We observed staff explaining to patients, carers and relatives about what was happening and when we spoke to these people they were always aware of what was going on, including when that was not known.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

There was good recognition and support for people for whom English was a second language. The area had a high population of people who spoke a variety of east European languages and while some staff were speakers themselves all staff had the facility to access telephone based language support services.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

We observed staff explaining to patients, carers and relatives the choices they had and they were given time to think and reflect. When we spoke to them they were aware of the decisions available to them.

**Emergency Department Survey 2016**

The feedback from the Emergency Department survey test was mostly similar to other trusts.

The trust scored worse than other trusts for one of the 24 Emergency Department Survey questions relevant to the caring domain and about the same as other trusts for the remaining 23 questions.

<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</td>
<td>8.5</td>
<td>About the same</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>nurses examining and treating you?</td>
<td></td>
<td>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>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</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local
organisations to plan care. However, the department was constrained by its size and the premises were not suitable for the number of patients who attended.

Managers planned and organised services so they met the needs of the local population.

When we last inspected the department in February the trust was working to implement new processes in the department in order to serve the needs of patients. We noted these were in their infancy and of limited effectiveness resulting in poor care for patients.

During this inspection we found many of these processes were becoming embedded and were operating effectively. During the three days of our inspection and an out of hours visit, we conducted later, the department experienced unusually low numbers of patients so we were not able to see how these systems worked under stress. Only one patient was observed held in the central area of the department when returning from an x-ray and this was for less than fifteen minutes.

There was an integrated streaming service in partnership with the local community trust where self-referring patients presented to a single reception desk and were streamed using a “visual assessment” either to see general practitioners under the community trust or be directed to A&E. Approximately 30-40% of patients went to the “GP stream” each day. The streaming facility was staffed from 8:30am to 11pm and we noted this working well with patients being streamed appropriately against the protocol. Outside of these hours all patients presented to the main A&E reception desk. The reception desk had two members of staff at all times. We noted that it operated effectively and that senior staff worked “hands on” so as to understand the needs of their staff.

Because of the small size and capacity of the department there were problems dealing with the variation in the numbers of patients attending and the department could quickly become overwhelmed. A trial had taken place using a Pre Hospital Practitioner (PHP) to care for patients who were waiting in a corridor area for treatment and to coordinate their admission into the department. They also coordinated patients who by necessity were waiting in ambulances because there was no room in the department, although during our inspection this did not happen.

This “corridor care” was effective and at its best we saw the PHP proactively monitoring inbound ambulances, liaising with staff about the availability of cubicles or resuscitation bays, cleaning and preparing spaces and working with reception staff to prepare paperwork. We also saw outstanding care and compassion being given to patients waiting in that area. However, both the efficacy of the process and the patient interaction was dependent on the staff on the day.

On one occasion we saw a consultant interfere in this process by questioning ambulance crews themselves before the patient had been nurse assessed and this caused a confused situation.

There were three cubicles dedicated to a Rapid Assessment and Treatment (RAT) process which had been introduced if the RAT cubicles were full then a maximum of three patients were cared for in the corridor by the PHP.

There were digital timers above the RAT cubicles to ensure that patients only stay for 15 mins in RAT but these were used inconsistently and sometimes when they were used they were not reset for the next patient meaning they could never be relied on. After the RAT process the pathway split to admitted / non-admitted patients. This was decided on by the nurse. We asked for the criteria for deciding this but we were told there was none.

If both the RAT cubicles and the corridor were full then “reverse RATting” was implemented where patients who had been “RATted” and were stable were “swopped” for a “corridor patient”. During the inspection the department was busy but not at full capacity and we saw the system operating as intended.

If patients could not be accommodated in the department they were kept in ambulances outside under the care of the crews but with assessment of the patient’s condition made by staff including when necessary doctors. During our visit only one patient was being cared for on an ambulance and this was because they refused to leave and enter the department. They were however assessed on the ambulance by a doctor.
All patients were logged onto a computer system and their status and risk scores displayed on a central screen. This was done well and senior staff made constant reference to this when planning how patients were to be treated and where they were going out of the department.

Facilities and premises were not appropriate for the services being delivered.

The department did not have sufficient physical capacity for the number of patients that often attended. The trust had made improvements to systems and was making best use of the space available but at the time of our inspection was prevented from expanding the department because of the location adjacent to a key hospital road and financial constraints. We were told that there were “worked up plans available off the shelf” but there was no intention to implement them.

The department was cramped with most of the cubicles located around a central area. This had the effect that senior leaders knew what was happening in the department but it compromised patients’ privacy. It also meant that the department felt crowded with staff and even when there were few patients it was noisy.

During our previous inspection in February 2018 we had noted that the department did not have audio and visual separation of children from adult patients. Since then the department had made changes, within the constraints of the estate to address this. Because of those constraints these adaptions were by necessity compromises and could not achieve the required standard. Some staff disagreed with the priorities that had been chosen but it was clear that the changes had been made in a rational and considered way and may well have been the best achievable.

A separate room had been built within the main reception area. It was suitably decorated and provided some visual and audio separation from the adults in the main area. One of the four resuscitation bays was allocated to children and was suitably decorated with toys available as distraction aids. It was located at the end of the resuscitation area and curtained off but there was no audio separation achievable.

A dedicated children’s cubicle had been provided and this was located at the far end of the department so as to be best separated from the sounds and sight of adult patients. A second cubicle usually reserved for infected patients was available opposite for a second child and this offered the advantage that a single nurse could oversee both. This location required children to be taken through the adult part of the department to the cubicles from reception or triage and staff told us that this could be distressing if the central area was full of patients on trollies. They tried to avoid this by taking children “round the back” if possible.

There were no disabled toilet facilities in the main area of the department, patients had to go through to reception where suitable facilities with an emergency alarm were located.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Staff told us that referral to psychiatric liaison nurses usually took place within one to two hours but sometimes sooner. Mental Health assessments took place in around two hours or four hours out of hours.

The service did not have systems to help care for all patients in need of additional support or specialist intervention.

Since our last visit in February 2018 a frailty pathway had been introduced and this was working well. The department was developing system to better support patients with dementia but this was at an early stage.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people’s individual needs

The service was not fully inclusive and did not take into account all patients’ individual needs and preferences. Important information was not readily available as leaflets for patients to take away. Staff made reasonable adjustments when possible to help patients access services but there were not good systems in place to help them do this. They
coordinated care with other services and providers.

There was a separate Ambulatory Emergency Care (AEC) unit which catered for those patients who could get around by themselves and who did not need to facilities of the main emergency department. This area was situated close to the main emergency department and had comfortable and spacious seating for patients and their relatives.

The department was on one level and accessible by wheelchair. However, there was not an accessible toilet in the main area, only reception and cubicles were cramped with little provision made for wheelchair users.

Staff could not make sure all patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Patients living with dementia were cared for with compassion but there were limited facilities available to support them. However, we saw that work had been started to improve this such as the development of a “dementia box”. There was also a liaison nurse identified.

Staff did not support all patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports.

We did not see any of these systems in use but there was a telephone referral system in place to access specialist learning disability nurses from another NHS trust. This was not available 24 hours a day.

The service did not have information leaflets readily to hand and available in languages spoken by the patients and local community.

There was limited information available on line in English and this could be printed out for patients to take away. However, the leaflets suggested that the material could be provided in other languages on request by email. This did not allow the information to be readily available at all times and was particularly concerning in the case of important information such as discharge advice to the parents of children with head injuries.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

There was good access to telephone based interpretation services.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff did not have access to communication aids to help patients become partners in their care and treatment.

Staff did not demonstrate they understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

There were no hearing loops installed in the reception area nor provision elsewhere in the department.

Emergency Department Survey 2016
The trust scored about the same as other trusts for each of the 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 (October 2016 to March 2017; published October 2017)
Access and flow

People could not always access the service when they needed it and did not always received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Median time from arrival to treatment (all patients)

Managers monitored waiting times and made sure patients could access emergency services when needed. However, patients frequently did not receive treatment within agreed timeframes and national targets.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard any of the months over the 12-month period from March 2018 to February 2019.

From March 2018 to February 2019 performance against this standard fluctuated between a high of 89 minutes (February 2019) and a low of 77 minutes (December 2018).

Median time from arrival to treatment from March 2018 to February 2019 at United Lincolnshire Hospitals NHS Trust

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

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

Managers and staff worked to make sure patients did not stay longer than they needed to. However, the department continually and significantly underperformed against both the target and other trusts.

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 emergency department.

From April 2018 to March 2019 the trust failed to meet the standard and performed consistently worse than the England average.

Four-hour target performance - United Lincolnshire Hospitals NHS Trust
Percentage of patients waiting more than four hours from the decision to admit until being admitted

From April 2018 to March 2019 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently worse than the England average.

From May 2018 to February 2019 performance against this metric worsened; however in the most recent month, March 2019, performance improved but was still worse than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - United Lincolnshire Hospitals NHS Trust

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

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

Over the 12 months from April 2018 to March 2019, three patients waited more than 12 hours from the decision to admit until being admitted: one patient each in September 2018, October 2018 and March 2019.

(Source: NHS England - A&E SitReps).
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

The number of patients leaving the service before being seen for treatments was high compared to the England average.

The trust was aware that some patients chose to leave the department and we saw posters on exits asking that staff were always informed before they did so as to prevent unwarranted concerns being raised.

From October 2018 to February 2019, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently worse than the England average.

In the most recent month, February 2019, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 5.0%, compared to the England average which was 1.8%.

With the exception of October 2018 to January 2019, the trust reported seven patients who left the trust’s urgent and emergency care services before being seen for treatment in June 2018 (0.1%) and no patients in August 2018. No data was submitted for the other months.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - United Lincolnshire Hospitals NHS Trust

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

From March 2018 to February 2019 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average.

From June 2018 to February 2019 performance against this metric worsened from 186 minutes to 222 minutes. In the most recent month, the median time at the trust was nearly 60 minutes worse than the England average of 165 minutes.

Median total time in A&E per patient - United Lincolnshire Hospitals NHS Trust
The department used a recognised scoring system to record operational pressures. This Operational Pressures Escalation Levels (OPEL) system scored the pressures on the department from 1 where demand can be met from within existing resources to 4 when organisations would not be able to deliver comprehensive care. During our inspection OPEL levels remained consistently at level 2.

The trust had an effective full capacity protocol which was used when demand outstripped the capacity of the department. Due to the frequent stresses on the department this was well practised and staff were familiar with it although it was not implemented during our inspection.

There was an emergency department risk tool which was updated hourly by an identified senior nurse for each shift. This was largely done on time during our inspection. The department also used an electronic patient record system to record all patients in the department, their acuity and the plans for their treatment or transfer. We noted this was kept up to date and was a focus of two hourly discussions that took place between the Emergency Practitioner in Charge (EPIC) and the senior nurse. We observed several of these “huddles” on different shifts and involving different staff and they were effective.

This information was fed into the trust operations centre which had an overview of the patient flows in the hospital. Bed meetings were routinely held three times a day with additional meetings as necessary although this was not required during our inspection. We attended two of these meetings and noted that they were run effectively.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Summary of complaints

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

The department had recognised that complaints were not being investigated in a timely fashion and had worked to address this. During our inspection we were told that there was no longer a backlog of complaints waiting to be addressed. We saw evidence that at the time of our visit there were only two complaints waiting investigation.
Trust level

From March 2018 to February 2019, the trust received 179 complaints in relation to urgent and emergency care (24.6% of total complaints received by the trust). The trust took an average of 48.6 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 35 working days, or 50 working days for more complex complaints. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>78</td>
<td>43.6%</td>
</tr>
<tr>
<td>Communication</td>
<td>26</td>
<td>14.5%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>20</td>
<td>11.2%</td>
</tr>
<tr>
<td>Values and behaviour</td>
<td>15</td>
<td>8.4%</td>
</tr>
<tr>
<td>Admission &amp; discharges (excluding delayed discharge due to absence of a care package)</td>
<td>13</td>
<td>7.3%</td>
</tr>
<tr>
<td>Patient care</td>
<td>10</td>
<td>5.6%</td>
</tr>
<tr>
<td>Facilities</td>
<td>4</td>
<td>2.2%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>No consent</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Delay in diagnosis</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Safeguarding - patient care</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Trust admin/policies/procedures including patient record management</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Safeguarding - communication</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>179</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

A breakdown by site can be seen below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital, Boston</td>
<td>86</td>
<td>47.9%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>73</td>
<td>40.8%</td>
</tr>
<tr>
<td>Grantham &amp; District Hospital</td>
<td>20</td>
<td>11.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>179</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Pilgrim Hospital

From March 2018 to February 2019, Pilgrim Hospital received 86 complaints in relation to urgent and emergency care. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>37</td>
<td>43.0%</td>
</tr>
<tr>
<td>Communication</td>
<td>16</td>
<td>18.6%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>9</td>
<td>10.5%</td>
</tr>
<tr>
<td>Values and Behaviour</td>
<td>5</td>
<td>5.8%</td>
</tr>
<tr>
<td>Facilities</td>
<td>4</td>
<td>4.7%</td>
</tr>
<tr>
<td>No Consent</td>
<td>3</td>
<td>3.5%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>3</td>
<td>3.5%</td>
</tr>
<tr>
<td>Admission &amp; Discharges (excluding delayed discharge due to absence of a care package)</td>
<td>3</td>
<td>3.5%</td>
</tr>
<tr>
<td>Access to Treatment or Drugs</td>
<td>2</td>
<td>2.3%</td>
</tr>
</tbody>
</table>
Prescribing 1 1.2%
Safeguarding - Communication 1 1.2%
Trust admin/policies/procedures including patient record management 1 1.2%
Safeguarding - Patient Care 1 1.2%
Total 86 100.0%

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

**Number of compliments made to the trust**

From March 2018 to February 2019, there were 1,831 compliments about urgent and emergency care at the trust. A breakdown of compliments by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham Hospital</td>
<td>1,507</td>
<td>82.3%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>137</td>
<td>7.5%</td>
</tr>
<tr>
<td>Pilgrim Hospital Boston</td>
<td>187</td>
<td>10.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,831</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The trust noted that, alongside the compliments received by wards and services, there were an additional 746 comments recorded trust-wide. These were comments from patients, families and staff directly to the services and staff they came in contact with. A theme from the compliments received trust-wide was good communication.

**Pilgrim Hospital**

From March 2018 to February 2019, there were 187 compliments about urgent and emergency care at Pilgrim Hospital. A breakdown of compliments by department is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Emergency Care</td>
<td>120</td>
<td>64.2%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>67</td>
<td>35.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>187</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The department had recognised from complaints received that because of the long wait times in the department access to food and drink was a significant issue for both patients and relatives. This had resulted in the introduction of “nutrition rounds” three times a day and the provision of drinks and high quality sandwiches.

**Is the service well-led?**

**Leadership**

Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, they were only starting to understood and manage the priorities and issues the service faced.
Since our last inspection in February 2019 the management arrangements for the emergency service at Pilgrim Hospital had undergone significant changes. In line with new trust management arrangements known as the Trust Operating Model (TOM) there were three senior leaders responsible for the service, a nurse, a manager and a doctor. This “triomvirate” had been recently recruited and were working to understand and address the issues that faced the department.

The department had also introduced a team of knowledgeable and experienced staff from leading children’s hospitals who were on secondment to develop skills, leadership and promote changes to systems to safely care for children. This “STRIKE Team” had clearly made an impact and was well engaged with the department. This was not only because of the efforts of the team but the manner in which staff had embraced the opportunities offered and how senior staff had provided role models for that.

When we interviewed these senior staff they demonstrated a good understanding of the challenges that the department faced and they were realistic about timescales and what could be achieved. Their views were consistent with the views of other senior staff outside of the immediate group and also those staff from other organisations who were working with the department to improve the service.

They described how a key goal was to do it the same across the sites and to get authority and responsibility as close to the patient as possible. They recognised that the clinical workforce had been disconnected from management and that medical and nursing staff had not worked well together.

Staff we spoke to at all levels were aware of the changes that were taking place and almost all were positive and looking to the future. A staff nurse who had worked in the department for two years told us that there had been a huge change in leadership and that leaders were approachable and valued. They also said the relationship between doctors and nurses had improved. This corroborated by other staff who commented on the positive changes in the department. Some staff commented that they had noted the way members of the “TOM” had been recruited and they believed that they provided good role models for the department.

Senior staff with a cross site role were seen to be visible on individual sites and locally based staff were aware of the days that they were present on each site. Nurses in charge reported having good support from more nurse leaders as they dealt with challenges in the department and their professional development.

We saw that where there had been failures in leadership, expectations had been set and staff given support and development. An example was the Standard Operating Procedure for the Emergency Practitioner in Charge (EPIC) role. This had resulted in improvement in leadership of shifts but also some staff had chosen to leave.

We were also told that there had not been good engagement from the most senior trust executives about the elements of the Full capacity Protocol that required the cooperation of other departments to move patients out of the Emergency Department. Leaders had achieved this by engaging directly with staff in other departments to gain their support. However, this had been successful and, for example, we saw medical staff from wards coming to the Emergency Department to help get patients transferred.

We also noted how leadership was supportive to staff when things did not go as planned. Staff had been upset by a recent “Ward Accreditation” audit in which the department had performed poorly but we saw that they spoke openly about this and were determined to improve. Senior staff told us “there were tears but then we picked ourselves up”.
A&E reception was staffed by two members of staff at all times despite staffing challenges and we noted that senior reception staff worked on the reception counter to keep their credibility and identify the problems that their staff encountered.

We saw strong and effective leadership demonstrated in achieving very difficult recruitment objectives for medical staff.

**Vision and strategy**

The service had a developing vision for what it wanted to achieve and a strategy was emerging to turn it into action. The vision and strategy were to be focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to deliver and monitor progress of the plans. However, the management team responsible for delivering this were very new in post and work was at an early stage.

When we spoke to members of the TOM and other senior leaders they were consistent in telling us what had happened so far and plans for the future.

We were told, and we saw from the improvements made and by talking to staff that current and recent focus had been on the key safety issues of triage, treating children and establishing leadership. The next immediate steps were address flow of patients and crowding in the department.

Their view was that the department had previously been wholly reactive and they saw their role as bringing a strategy and vision. This needed to be achieved in the context of the trusts financial recovery programme and that could only be achieved by addressing the staffing costs in the department caused by high levels of agency and locum use. There was a recognition that recruitment was very difficult for the Pilgrim Hospital and that they needed to be innovative in attracting and retaining staff with better opportunities for career development than were currently provided. This focus on recruitment and staff retention would have wider benefits in improving skill levels and mix. Senior leaders recognised the long term nature of this approach and talked of not achieving full benefit for four to six years.

It was recognised that similar issues had been successfully addressed in another multisite trust that had a geographically isolated emergency department and the department was engaged with that trust to learn from them.

When we spoke to staff they were positive about the new approach although some expressed caution and others offered the view that in the past changes had not always “stuck” and become embedded.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear. However, there were still issues with some staffs’ behaviours and the positive changes were not yet fully embedded. There was also limited opportunities for career development.

In our previous inspection in February 2018 we had raised concerns about morale in the department and that staff did not feel respected or valued by their managers. During our most recent inspection we found that morale had improved and that staff now spoke differently about their leaders.
A staff nurse who had worked in the department for two years told us there had been “huge changes” and that they now felt valued. Other staff at different levels commented on the positive changes in the department.

An administrator told us that they had observed in the past that “some doctors behaviours were not the best” but that things were “now sorted out” and they noted clinical staff “working together and discussing risks”. This was a theme that a number of staff mentioned to us; that working relationships between medical and nursing staff were improved and we noted this had been an issue that the managers had directly addressed.

Another manager told us “there has been a culture shift”, “the staff felt done to but now they are on board”. This chimed with the views of a senior clinical leader who told us that the biggest challenge had been and still was values and behaviours. They believed that although there had been significant improvement it was not yet fully embedded and there was still a risk of reverting to previous behaviours.

There was information in the department about the duty of candour and staff were able to articulate what was expected of them by the trust. There was also information about whistleblowing and speaking up. Some staff told us of occasions when they had done so.

There was also the recognition that the TOM approach was also about establishing personal performance expectations and that while staff would be offered support and development opportunities there was a performance management element and staff would need to embrace the shift in expectations.

Some staff expressed the view that initiatives had been tried before but come to nothing. However, this was something recognised by a member of the TOM who commented that while staff were enthusiastic they were not confident that they would get the support.

Members of the STRIKE Team told us they had observed a cultural change in the department and that one aspect that had improved was the attitude to patient safety. Staff to whom we spoke did talk about the need to be open and challenging to improve safety and were prepared to discuss examples of when things had gone wrong without being defensive.

Some staff spoke to us about bullying and favouritism in different staff groups and said that there were still cliques that existed. One manager gave clear examples of how two members of their team had been treated improperly by senior staff from another profession and how this had resulted in them both leaving.

A recently recruited member of staff told us that they had been welcomed and liked the team who all worked hard, However, they also said that it was upsetting and disheartening when the capacity of the department was high and they could not get patients out of the department.

During our inspection we noted that almost all staff acted in a caring and compassionate manner. However, we were surprised on a few occasions about the attitudes that staff displayed. On one occasion a senior nurse reacted to an issue to which we needed to draw to their attention in a disinterested fashion. On another a member of staff went about their duties in a perfunctory manner despite knowing they were under observation.

**Governance**

Leaders operated governance processes, throughout the service and with partner organisations. However, these were still under development and not fully embedded throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
Governance arrangements had and were improving at the time of our inspection. The structures had been improved with the establishment of the Trust Operating Model and the appointment of credible leaders amongst the medical staff.

Those systems that we noted as being in their infancy during our inspection in February 2018 were maturing although not yet fully embedded. Although improved there was still inconsistency of processes across the department and in some instances we found that there was more than one process in place. This inconsistency was still sometimes associated with the senior staff on duty’s preferred approach but also that new processes were introduced without a strong structure and expectation that they must be used. Some of the language was telling; we were told for example that change needed to be introduced “gently” or that staff’s feelings needed to be considered. This however had the undesired effect that processes intended to reduce risk actually introduced additional risks. This inconsistency of implementation was also raised with us as a risk by staff.

The TOM Team were establishing governance arrangements which made them available to work together regularly as a group but also to make them available to other staff and managers. Regular Emergency Department governance meetings were taking place at a specified time on a specified day known as “Business Wednesday”. This brought a consistency of approach that ensured everyone knew when do be available and had little excuse not to be. One Wednesday of the month was planned to be flagged as when the TOM Team would be available to the trust Executive Team and this set an expectation that they acknowledged the responsibility to be accountable but also expected support.

We noted that a newly established arrangement was alternate weekly meetings between the Emergency Department and the local community NHS trust to discuss the performance of the streaming service.

Team meetings were taking place for medical and nursing staff and we noted that efforts were made to ensure everyone was informed even if they could not attend through the use of communication books and staff briefings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Since our last inspection in February 2018 the department had introduced processes to identify and manage risk, issues and performance.

Every two hours the EPIC discussed the situation in the department with the nurse in charge in what was termed a “safety huddle”. This was required to take place by the Emergency Practitioner in Charge Standard Operating Procedure and the discussion was recorded on a form and stored in a file. Each “huddle” discussed the status of individual patients, the plans for them and any current and expected pressures on the department. When we observed these meetings we found them effective.

Much of this discussion was aided by a large electronic information display which for each location such as a cubicle or resuscitation bay displayed the key details about the patient including any risk flags or scores and the next stage in their pathway through the department.

There was also a system to record the situation in the department and calculate a risk score which relied on a named nurse inputting a set of data each hour. We noted this was usually done on time and the status and calculated risk state was displayed on a video monitor in the department.

This information was fed into the trust operations centre which had an overview of patient flow in the hospital. Bed meetings were routinely held three times a day with additional meetings as
necessary although this was not required during our inspection. We attended two of these meetings and noted that they were run effectively.

During our inspection, although the trust was not under pressure due to demand, there was a threat to the hospital that was declared a ‘pre-major’ incident. Due to extreme weather the boiler house had become flooded and there was a risk of the hospital losing some essential services. However, due to the efforts of the hospital’s estates staff and the Fire and Rescue Service the threat had been mitigated by the first morning of our inspection. Because of the pre major incident status the trust had setup planning cells which were preparing for the loss of services.

Management of the emergency department around capacity, flow and the ability to cope with surges of demand appeared on the corporate risk register and were scored at the highest possible level. The trust wide risk of workforce capacity and capability was also scored at the highest level and this was noted as a risk that significantly affected the Emergency Department.

There was an Urgent and Emergency Care Board and plan which maintained oversight of issues and there was local surveillance by the Lincolnshire Sustainability and Transformation Partnership.

At our previous inspection we noted that some senior leaders had poor knowledge of national guidance and performance outcomes relevant to the emergency department. We noted that the upcoming recruitment of permeant staff into these roles would address this over time but there was still a lack of knowledge and awareness among some senior medical staff. When we asked them about actions from RCEM audits the department had taken part in some senior leaders could not offer any information.

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. We noted that the Major Incident Plan and Chemical biological Radiological Nuclear (CBRN) had been updated in September 2018.

**Information management**

The service collected some data and analysed it. Staff could find some data they needed to manage the department on a day to day basis. The information systems were secure. Data or notifications were consistently submitted to external organisations as required. However, there was not an integrated approach to the collection, analysis and use of information and it was not available to make day to day decisions.

There were discrete systems in place to identify day to day risks in the department and to manage patients. We saw that these systems were kept updated and used effectively but they did not form an overall picture.

As part of our ongoing monitoring of the department as a result of the conditions imposed by the Care Quality Commission the department regularly submitted information about the performance of the department and adherence to the conditions. Systems had been put in place to facilitate this and the data received was fit for purpose.

There was not an overall strategy for information in the department and when we discussed this with managers we noted that they were aware of this stating that there was a “need to add support for management information”. They further explained saying that they had ambition to develop real time information dashboards at individual and team levels and that this would be realised through the planned transformation work.

We did not see any records or information stored inappropriately during our visit. Records for patients were available from the well managed store in the reception area and those for patients in the department were available to the staff caring for the patients.
Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

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.

When we spoke to staff about how recent changes had been implemented and their view on the future of the department they told us that there was greater consultation than previously. A common phrase was that staff no longer felt “done to”.

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 within the Lincolnshire Sustainability and Transformation Partnership.

Learning, continuous improvement and innovation

Staff showed commitment and enthusiasm for learning and for improving services. However, the opportunities were not always there for them. Understanding of quality improvement methods was low and there was little evidence of innovation and participation in research.

As identified in our previous inspection in February 2018 there was not a culture or track record of continuous learning, improvement and innovation in the department.

This was recognised by the managers in the department and they were addressing this through the plans for the department. However, there was a candid view that it would be some years before clinical teams were doing this effectively.

It was clear that improvement and innovation had taken place particularly around the safety of children in the department and this had been supported and driven by the presence of the STRIKE Team. A legacy of this was the identification of “paediatric champions” and the planned recruitment of a Paediatric Clinical Educator to emulate what the STRIKE Team had been doing.

Members of the STRIKE Team told us that there was a genuine enthusiasm to listen and learn but the larger organisation and staffing issues in the department made it difficult to do things at a pace. Examples were getting staff released for training, not only because of availability but because of the financial implications of getting cover and identifying suitable training locations within the hospital.

It was of note that when we were talking to members of the STRIKE Team in the department we were interrupted several times by staff who wanted them to “sign off” on some of the skills and training they were doing. Their enthusiasm and appetite for this professional development was highly evident.
Medical care (including older people’s care)

Facts and data about this service

The trust provides medical care (including older people’s care) at three sites: Grantham and District Hospital; Lincoln County Hospital; and Pilgrim Hospital. Services at all sites sit within the division of medicine and are managed through the cardiovascular and specialty medicine clinical business units.

The trust has 546 inpatient medical beds across Lincoln County Hospital and Pilgrim Hospital, with 300 of these beds being located at Lincoln County Hospital.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 72,242 medical admissions from January to December 2018. Emergency admissions accounted for 33,181 (45.9%), 1,269 admissions (1.8%) were elective, and the remaining 37,792 (52.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 31,313 admissions
- Clinical haematology: 7,985 admissions
- Clinical oncology: 7,447 admissions

(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 service did not make sure all staff completed mandatory training in key skills. The number of staff who completed it did not meet trust targets.

The trust set a target of 90% for completion of mandatory training, with the exceptions of:

- Fraud awareness and infection prevention level one, which had targets of 95%.
- Local fire procedures and fire safety, which had targets of 100%.
- Immediate life support (ILS)/advanced life support (ALS) and medicine management training, which had no targets. The trust informed us that the eligible numbers of staff were not available for these two courses and therefore we were unable to calculate completion rates.

A breakdown of compliance for mandatory training courses as of February 2019 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; safety</td>
<td>604</td>
<td>622</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>602</td>
<td>622</td>
<td>96.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>601</td>
<td>622</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>593</td>
<td>622</td>
<td>95.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>584</td>
<td>622</td>
<td>93.9%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>584</td>
<td>622</td>
<td>93.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>569</td>
<td>622</td>
<td>91.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>562</td>
<td>622</td>
<td>90.4%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>540</td>
<td>622</td>
<td>86.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>538</td>
<td>622</td>
<td>86.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>533</td>
<td>622</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>269</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>111</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

In medicine, the target was met for four of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.
A breakdown of compliance for mandatory training courses as of February 2019 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>103</td>
<td>108</td>
<td>95.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>103</td>
<td>108</td>
<td>95.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>102</td>
<td>108</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>101</td>
<td>108</td>
<td>93.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>98</td>
<td>108</td>
<td>90.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>97</td>
<td>108</td>
<td>89.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>91</td>
<td>108</td>
<td>84.3%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>90</td>
<td>108</td>
<td>83.3%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>87</td>
<td>108</td>
<td>80.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>86</td>
<td>108</td>
<td>79.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>71</td>
<td>108</td>
<td>65.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>6</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>5</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

In medicine, the target was met for four of the 11 applicable mandatory training modules for which medical staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

Nursing staff did not always receive and keep up to date with their mandatory training.

A breakdown of compliance for mandatory training courses as of February 2019 for qualified nursing staff in the medicine department at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>172</td>
<td>174</td>
<td>98.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>171</td>
<td>174</td>
<td>98.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>168</td>
<td>174</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>167</td>
<td>174</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>163</td>
<td>174</td>
<td>93.7%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>162</td>
<td>174</td>
<td>93.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>157</td>
<td>174</td>
<td>90.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>151</td>
<td>174</td>
<td>86.8%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>151</td>
<td>174</td>
<td>86.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>148</td>
<td>174</td>
<td>85.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>135</td>
<td>174</td>
<td>77.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>30</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>68</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital medicine department, the target was met for four of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

Medical staff did not always receive and keep up to date with their mandatory training.

A breakdown of compliance for mandatory training courses as of February 2019 for medical staff in the medicine department at Pilgrim Hospital is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>28</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>27</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>25</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>25</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>24</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>24</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>24</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>23</td>
</tr>
<tr>
<td>Information governance</td>
<td>22</td>
</tr>
<tr>
<td>Fire safety</td>
<td>21</td>
</tr>
<tr>
<td>Basic life support</td>
<td>19</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>4</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>2</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital medicine department, the target was met for two of the 11 applicable mandatory training modules for which medical staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

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

The mandatory training was comprehensive and met the needs of patients and staff. For example, staff told us the quality of training was good and helped them to keep up to date with the latest standards of care and national guidelines.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. However, as large numbers of clinical staff were agency or locum staff, the trust could not be assured of the consistency of the standard of training. This was because most temporary staff underwent training with their employer and not with the trust.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, high vacancy rates in most medical areas meant staff could not always access training updates in a timely manner.

Training completion amongst allied health professionals (AHPs) was 96%.

Staff described significant changes to fire safety training, including simulated exercises that required them to evacuate ‘patients’ with sensory deprivation. The trust had also improved the fire safety induction agency nurses carried out.

Improving completion rates of mandatory training was a clear priority for senior ward staff and we saw evidence this had broadly improved since the trust submitted the data included above. For example, in June 2019 the team on ward 6B had 97% overall compliance and on ward 7B the team had 93% compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
The trust set a target of 90% for completion of safeguarding training.

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of February 2019 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>558</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>557</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>535</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>534</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>2</td>
</tr>
</tbody>
</table>

In medicine the 90% target was not met for any of the five safeguarding training modules for which qualified nursing staff were eligible. However, the completion rates for the safeguarding adults and children level 1 modules were only slightly below the target.

A breakdown of compliance for safeguarding training courses as of February 2019 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>94</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>94</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>88</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>88</td>
</tr>
</tbody>
</table>

In medicine the 90% target was not met for any of the four safeguarding training modules for which medical staff were eligible.

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of February 2019 for qualified nursing staff in the medicine department at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>155</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>155</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>143</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>143</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>0</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital medicine department, the 90% target was not met for any of the five safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of February 2019 for medical staff in the medicine department at Pilgrim Hospital is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>27</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>27</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>25</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>25</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital medicine department, the 90% target was met for two of the four safeguarding training modules for which medical staff were eligible.

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. For example, staff said this was part of their training and said they would take immediate action if they observed patients experience discrimination.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, all staff knew how to escalate a situation urgently to the safeguarding team and to the local authority crisis team during out of hours periods.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. This included the trust safeguarding team and the local authority team. Where patients had been admitted from another local authority area, staff knew how to find the contact details for the relevant team.

Staff followed safe procedures for children visiting the wards and restricted access where this could be harmful. For example, ward managers implemented temporary restrictions where they felt children might be at risk of harm when they visited, such as when patients with reduced mental capacity behaved unpredictably or violently.

All senior AHPs, external speech and language therapists (SaLTs) and musculoskeletal (MSK) therapists held safeguarding adults and children level 3 training. All other therapists were trained to a minimum of level 2.

**Cleanliness, infection control and hygiene**

The service did not always control infection risk well. However, staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All clinical areas were clean and had suitable furnishings, which were clean and well-maintained. However, audits showed compliance with trust standards was generally low and several wards had rates at less than 90%. We spoke with senior nurses about this who said compliance had gone down due to the extensive building works ongoing in the wards, which had resulted in areas becoming dusty and dirty. We saw construction workers needed frequent access to patient areas in wards and did not adhere to hand hygiene principles. Staff did not challenge them with this and we were unable to establish why the trust had not enforced basic hygiene standards with contractors.

The service score for cleanliness was worse than the England average score for cleanliness, of 99%, in the patient-led assessment of the care environment (PLACE). In this assessment the hospital scored 93% in 2018.
Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Housekeeping staff used daily and weekly checklists to ensure they cleaned each area in line with trust standards. We looked at a sample of 21 cleaning checklists, with at least one in each ward or department, and found them all to be up to date.

Staff followed infection control principles including the use of personal protective equipment (PPE). For example, we observed staff use disposable gloves and aprons appropriately. Housekeeping staff adhered to the colour coded mop and bucket system to avoid cross-contamination. Staff displayed notices on the bedroom door of patients cared for in isolation due to an infection control risk. We observed housekeeping staff followed these instructions meticulously. Housekeeping staff used a daily checklist to manage infection control for isolation areas. We reviewed a sample of three checklists on ward 6A and found them to be fully up to date with no gaps in recording.

All staff in the endoscopy unit responsible for decontamination processes had up to date competency-based training and equipment-specific cleaning training based on manufacturer guidance. Healthcare support workers (HCSWs) led the decontamination process and we saw they used well-established processes to reduce the risk of cross-contamination. The service was fully compliant with the Department of Health and Social Care (DH) Health Building Note (HBN) 00/09 in relation to infection control in the built environment and with HBN 00/10 in relation to infection control and flooring. Decontamination standards were in line with Department of Health and Social Care (DH) Health Technical Memorandum (HTM) 01-06.

Staff used an electronic system to track endoscopes and decontamination. This logged each endoscope to a specific procedure and patient in line with national best practice and this information was stored and tracked digitally.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. For example, staff used bright green ‘I’m clean’ on equipment to note when it had been cleaned and was ready for use. We saw staff use this process consistently.

The medical wards used a specialist team to clean quarantined areas where there was an infection or contamination risk. The acute medical short stay (AMSS) unit had eradicated norovirus over winter 2018.

Staff used an integrated care pathway to coordinate care for patients who tested positive for methicillin-resistant Staphylococcus aureus (MRSA) colonisation on admission. We reviewed the documentation of one patient who had tested positive for MRSA and found significant gaps in required information. Staff had noted a positive MRSA test result eight days previously and that they had started a medicine cycle but not the date this started. Documentation in two other records were more consistent.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the national early warning score (NEWS) system to monitor each patient’s condition electronically. When NEWS identified deterioration, staff escalated their care to the critical care outreach team (CCOT). CCOT provided an on-call 24-hour service to medical inpatient wards for deteriorating patients. Advanced nurse practitioners with airway and prescribing skills responded to patient escalations. We observed the process in practice in the IAC during a patient deterioration with cardiac problems. We observed a rapid response from the CCOT nurse and good standards of communication skills. However, we were not assured that
nurses on the IAC had the skills or competencies to respond appropriately to acute care. For example, the CCOT nurse had to ask six times for someone to bring magnesium for the patient. This caused some confusion amongst staff nurses because the ward did not stock magnesium and it had to be obtained centrally. In addition, the patient needed a cardiac monitor, which had to be obtained from the acute cardiac unit (ACU). This resulted in a nurse from the ACU leaving the unit to deliver the monitor. The ACU was already operating at reduced nurse staffing and this further increased risk.

Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. Risk assessments included for falls, pressure ulcers, social care needs, nutrition and hydration and any specific risks caused by the patient’s condition.

Staff knew about and dealt with any specific risk issues, including venous thromboembolism (VTE). VTE had been an area of focus for the trust following a previous inspection in which we found standards of risk assessment were inconsistent.

Medical wards used the national Sepsis 6 pathway of care bundle. We checked patient records to ensure they were complete and correct. A dedicated sepsis practitioner was based on site and worked to improve compliance with initial screening and antibiotics administration within the first ‘golden’ hour of recognition. A sepsis task & finish group led a quality & safety improvement plan (QSIP) to improve standards following the completion of a commissioning for quality and innovation (CQUIN) programme that ended in March 2019. At the end of this programme, the hospital achieved 70% compliance with national standards for initial screening and 90% for the timely administration of antibiotics. The sepsis practitioner was working with each ward that had not achieved 100% compliance to identify opportunities for training and improvement. They had completed a ‘train the trainer’ resource pack that would be rolled out from September to support development.

Sepsis link nurses were in post on some wards and supported staff to screen patients promptly. As part of a programme to improve compliance with the deteriorating patient bundle, the sepsis practitioner was working with deteriorating patient ambassadors to ensure sepsis screening was part of their role. This was a new initiative that would be launched from September 2019.

The sepsis practitioner had identified gaps in information sent to agency nurses ahead of shifts, which meant they were not always prepared to adhere to the trust’s sepsis screening requirements. The practitioner found over 50% of agency nurses had not received a required sepsis workbook ahead of their shift, despite assurances from the trust that this had been sent out. They were working to address this problem.

A dedicated tissue viability nurse worked across the trust to improve practice and reduce the risk of pressure ulcers. The nurse worked responsively to wards with increasing numbers of incidents and had introduced a new investigation process for grade 3 and 4 and unstageable pressure ulcers. A weekly pressure ulcer scrutiny panel maintained oversight of pressure ulcer management and promoted adherence to national standards. The IAC was an area of high risk due to the amount of time patients could wait after presenting in the emergency department before being admitted. The scrutiny panel found staff in the IAC did not consistently document their findings or initiate care plans promptly and were working with the team to improve this.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient’s mental health.

Staff had not completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. For example, we found discrepancies and
inconsistencies in the medical records of one patient with a known suicide risk. Staff did not demonstrate clear understanding of the processes or tools available to them to fully assess the patient’s needs and risks.

Staff shared key information to keep patients safe when handing over their care to others. However, staff in medical specialties said it was often challenging to obtain medical support overnight. For example, one trust grade doctor and one specialist registrar were responsible for covering medicine overnight and for supporting acute medicine for urgent cases. Staff on wards said this led to significant delays when they needed help for a patient, such as a warfarin or fluids prescription. One senior nurse said, “It feels isolated overnight, it’s a struggle to get any medical input.”

There were unmet risks to patients in the chemotherapy suite caused by gaps in the service when locum consultants were covering the service. Staff said locum consultants often refused to prescribe chemotherapy because they did not know patients, which reduced the continuity of care and resulted in delayed treatment whilst nurses sought prescriptions from permanent consultants based elsewhere in the trust’s group.

Shift changes and handovers were inconsistent across medical services and did not always include all necessary key information to keep patients safe.

We observed four board rounds; one each on wards 6A and 6B and the AMSS and IAC. They were well coordinated with a clear, detailed and appropriate plan for each patient. A range of multidisciplinary professionals were present for each and worked together to identify the best forward plan for each patient. Communication problems with other departments had an impact on patients and in some cases delayed care. For example, the radiology department had cancelled a scan because there was no porter available to take the patient. Another patient had a delay to care because the site team could not secure an additional nurse to escort them to another hospital in the trust’s group. Staff also spent time trying to find out why a patient was confused and why another patient had been sent for an x-ray. Although the process demonstrated a high standard of care and practice, it also highlighted a need for more coordinated communication between departments. The team used the board rounds to problem-solve and identify effective solutions to these challenges to reduce delays to care.

On IAC, consultants were not always present during evening handovers with junior doctors. This meant there was limited senior oversight and understanding of the contemporaneous pressures of the shifts. There were some ambiguities in understanding of who was responsible for each patient. We found it was a common occurrence on most shifts for a patient’s clerking or treatment to be delayed, by four to six hours, because the senior clinical team overlooked them. There was no effective tracking system in place for patients and staff did not always know whether patients had been referred to medicine for an inpatient admission or just for advice.

Shortages in AHP staffing levels meant care was sometimes delayed. For example, we found a delay in dietician review to one patient resulted in increased risk to the patient through uncontrolled body mass index increases and a delay in starting enteral feeding. We spoke with the dietetics team about this who responded immediately to rectify the situation.

During our weekend unannounced inspection, we reviewed the care provided for medical patients accommodated as outliers on surgical wards. This occurred where a patient needed to be admitted but there were no medical beds available. At the time of our inspection, two patients were being cared for as outliers. There were gaps in consultant review for both patients and one had not been seen for five consecutive days. This presented a risk as the patient had been transferred between wards on four occasions and we were not assured the medical team had maintained
consistent oversight. Nurses spoke variably of the responsiveness of the on-call medical team. One surgical nurse said it was easy to get a medical review and another said it was challenging. For example, one nurse said there were no medical consultants covering outliers during the week and it could “take hours” to find someone to review a patient.

The haematology suite had a dedicated sepsis bay and all staff had training in managing neutropenic sepsis. All staff in this unit had immediate life support (ILS) training.

A chemotherapy trained nurse was based on the oncology ward 24-hours a day.

Staff in the endoscopy unit and the chemotherapy suite saw patients on an outpatient basis and we observed receptionists and clinical staff follow national best practice guidance when confirming each patient’s identity. This included using three distinct identifiers to ensure they had the correct patient.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We observed consistent practice in this care standard throughout our inspection. When wards operated with fewer than planned staff numbers, the team took extra care to ensure they minimised delays in responding to patient’s needs.

The design of the environment followed national guidance issued by the Department of Health and Social Care (DH), including health technical memorandum (HTM) XX in relation to the built clinical environment. This meant patients were cared for in appropriate environments designed for clinical purposes.

Staff did always carry out daily safety checks of specialist equipment. Some equipment we checked was not always in date and some electrical safety testing and electrical checks had expired. Staff said the facilities team provided a prompt service to repair equipment.

We checked resuscitation (crash) trolleys in each clinical area we inspected. Overall standards were consistent, with no gaps in daily or weekly documentation and good standards of stock control. We found one item of expired disposable equipment across all areas, which staff replaced immediately.

Equipment management and stock control on AMSS required improvement. An oxygen cylinder on AMSS required reconditioning in April 2018 and the most recent documented service before that was in 2014. Foam and carbon dioxide fire extinguishers on this ward were due to be serviced the month of our inspection and two floor buffers and a vacuum cleaner had expired check dates. One toilet and sink had been out of use for over a week and staff did not know when this would be ready for use again. One stock room on this ward had expired supraglottic airways I-gel, one of which was five years out of date.

The service had suitable facilities to meet the needs of patients’ families. This included areas they could make drinks and snacks if this was safe and appropriate in the ward environment. Staff facilitated overnight stays for the relatives of patients who were very unwell and ensured they had access to quiet, private space when needed.

The service did not always have enough suitable equipment to safely care for patients. For example, staff in the IAC struggled to find and transfer cardiac equipment during an emergency situation. However, the facilities and estates team provided 24-hour access to the medical equipment library, which meant staff should have been able to access vital equipment on demand.
Staff disposed of clinical waste safely. For example, we observed good waste streaming practices in line with the Department of Health and Social Care Health Technical Memorandum (HTM) 07-01.

However, staff did not always follow best practice guidance from the Control of Substances Hazardous to Health (COSHH) Regulations 2002. For example, staff did not always store chemicals in secured areas with restricted access. We spoke to housekeeping who assured us COSHH controlled substances were always locked away where they could not be accessed by patients or the public. This was not the case in every area we inspected. Procedures were in place for the safe management of hazardous waste, including storage and disposal, in line with Department of Health and Social Care health technical memorandum (HTM) 07/07.

Staff managed sharps in line with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 and waste in line with Department of Health and Social Care national guidance on the management of healthcare waste.

Doors were marked with fire safety notices, such as instructions to keep them closed or to keep them locked. For example, on one day of our inspection on ward 7B we found three doors marked as fire doors to be kept closed were open and unmonitored. This means they would not provide effective protection in the event of a fire.

Staff had access to rapid delivery of special mattresses for patients with pressure area needs and a trust key performance indicator ensured these were delivered within four hours of request.

Processes to dispose of equipment were not robust. We observed abandoned equipment in various areas of wards and access points to wards. For example, a mobile chair had been left outside of ward 6A with a handwritten note to state it had been condemned seven weeks previously.

In the 2018 PLACE assessment, the hospital scored 91% for condition, maintenance and appearance of wards. This was slightly worse than the national average of 94%.

**Nurse staffing**

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. However, such reviews were often superfluous as there were no reserves of staff to backfill posts.

The service did not have enough nursing staff of all grades to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Internal standard operating procedures established minimum safe staffing levels. However, these were not consistently adhered to in inpatient areas.

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for medical care.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>149.2</td>
<td>202.2</td>
</tr>
<tr>
<td>Pan trust*</td>
<td>23.9</td>
<td>24.9</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>523.0</td>
<td>649.8</td>
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</tbody>
</table>
* The trust informed us that some staff worked over multiple sites. These staff are included under ‘pan trust’ above.

From April 2017 to March 2018, the nursing staffing rate within medicine was 80.5%. This was similar to the rate of 81.2% in the more recent period from April 2017 to February 2019.

The number of nurses and healthcare assistants on all shifts on each ward did not always match the planned numbers.

Fill rates greater than 100% indicate there were more WTE in post than originally planned.

Pilgrim Hospital reported the following WTE nursing staff numbers for the periods below for medicine. There are 18 units within medicine at this location so the five with the lowest fill rates in the later time period have been included, along with the total for all 18 units.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Stroke unit</td>
<td>17.0</td>
<td>28.4</td>
</tr>
<tr>
<td>Ward 8A</td>
<td>13.4</td>
<td>21.6</td>
</tr>
<tr>
<td>Ward 7B respiratory</td>
<td>16.9</td>
<td>23.2</td>
</tr>
<tr>
<td>Ward 6A</td>
<td>11.6</td>
<td>23.2</td>
</tr>
<tr>
<td>Acute medical short stay unit</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Site total</td>
<td>149.2</td>
<td>202.2</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the nursing staffing rate within medicine at Pilgrim Hospital was 73.8%. This was lower than the rate of 66.7% in the more recent period from April 2018 to February 2019, due to a greater increase in the total number of planned staff compared to the total number of staff in post.

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

Ward managers could adjust staffing levels daily according to the needs of patients. However, shortages across all medical areas were profound and senior staff said they rarely received the additional staff they needed.

The service had persistently high vacancy rates in inpatient areas. The chemotherapy suite had a full establishment of nurses.

From April 2018 to March 2019, the trust reported a vacancy rate of 21.2% for nursing staff in medicine. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Pilgrim Hospital medicine department: 32.6%

A breakdown of the five highest vacancy rates by ward at Pilgrim Hospital is below:

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute medical short stay unit</td>
<td>56.8%</td>
</tr>
<tr>
<td>Ward 6A</td>
<td>48.5%</td>
</tr>
<tr>
<td>Ward 7B respiratory</td>
<td>47.3%</td>
</tr>
<tr>
<td>Ward 8A</td>
<td>45.6%</td>
</tr>
<tr>
<td>Stroke unit</td>
<td>41.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
The service had variable turnover rates. The respiratory ward vacancy rate had increased to 55% between the date the trust submitted the above data and the date of our inspection. Senior staff described long-standing recruitment issues.

From April 2018 to March 2019, the trust reported a turnover rate of 7.4% for nursing staff in medicine. This was lower than the trust target of 8%.

- Pilgrim Hospital medicine department: 6.4%

A breakdown of turnover rates by ward is below.

Seven of the 19 medical wards had turnover from April 2018 to March 2019. The five wards with the highest turnover are shown below:

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute cardiac unit</td>
<td>17.0%</td>
</tr>
<tr>
<td>Pilgrim stroke unit</td>
<td>14.6%</td>
</tr>
<tr>
<td>Pilgrim endoscopy</td>
<td>8.3%</td>
</tr>
<tr>
<td>Ward 6A</td>
<td>8.3%</td>
</tr>
<tr>
<td>Ward 8A</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

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

Each ward had sickness rates above the trust target.

From April 2018 to March 2019, the trust reported a sickness rate of 4.7% for nursing staff in medicine. This was higher than the trust target of 4.5%.

- Pilgrim Hospital medicine department: 4.4%

A breakdown of the five highest sickness rates by ward is below.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly care specialist nursing</td>
<td>9.6%</td>
</tr>
<tr>
<td>Diabetic nursing</td>
<td>8.1%</td>
</tr>
<tr>
<td>Ward 8A</td>
<td>7.1%</td>
</tr>
<tr>
<td>Stroke unit</td>
<td>6.4%</td>
</tr>
<tr>
<td>Planned investigation suite</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

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

The table below shows the numbers and percentages of nursing hours in medicine at trust level from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 1,328,038 total working hours available, 8.2% were filled by bank staff and 13.6% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 6.3% of the available hours with either bank or agency staff.

Of the 742,665 total working hours available, 26.0% were filled by bank staff and 0.3% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 3.0% of the available hours with either bank or agency staff.
The service had substantial rates of bank and agency nurses used on the wards.

The tables below show the numbers and percentages of nursing hours in medicine at Pilgrim Hospital from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 401,985 total working hours available, 9.2% were filled by bank staff and 17.9% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 12.7% of the available hours with either bank or agency staff.

The five departments with the highest numbers of combined bank, agency and unfilled hours are shown in the table below.

<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018 to February 2019</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Ward 7B</td>
<td>45,326</td>
<td>3,056</td>
<td>6.7%</td>
<td>14,322</td>
</tr>
<tr>
<td>Ward 8A</td>
<td>42,197</td>
<td>7,143</td>
<td>16.9%</td>
<td>14,296</td>
</tr>
<tr>
<td>Ward 6A</td>
<td>45,326</td>
<td>5,583</td>
<td>12.3%</td>
<td>8,518</td>
</tr>
<tr>
<td>Ward 6B</td>
<td>45,326</td>
<td>4,080</td>
<td>9.0%</td>
<td>11,391</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>55,611</td>
<td>5,189</td>
<td>9.3%</td>
<td>9,640</td>
</tr>
<tr>
<td>Core service total</td>
<td>401,985</td>
<td>36,975</td>
<td>9.2%</td>
<td>72,077</td>
</tr>
</tbody>
</table>

Of the 277,763 total working hours available, 27.2% were filled by bank staff and 0.4% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 4.7% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018 to February 2019</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Ward 8A</td>
<td>37,113</td>
<td>17,625</td>
<td>47.5%</td>
<td>99</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>32,185</td>
<td>11,449</td>
<td>35.6%</td>
<td>15</td>
</tr>
<tr>
<td>Ward 6A</td>
<td>38,012</td>
<td>8,389</td>
<td>22.1%</td>
<td>12</td>
</tr>
<tr>
<td>Ward 7B</td>
<td>33,085</td>
<td>8,609</td>
<td>26.0%</td>
<td>0</td>
</tr>
<tr>
<td>Acute Cardiac Unit</td>
<td>13,883</td>
<td>6,127</td>
<td>44.1%</td>
<td>0</td>
</tr>
<tr>
<td>Core service total</td>
<td>277,763</td>
<td>75,561</td>
<td>27.2%</td>
<td>1,197</td>
</tr>
</tbody>
</table>

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

Managers requested staff familiar with the service.
Managers made sure all bank and agency staff had a full induction and understood the service.

It was not common practice on all wards to hold a daily safety huddle. This process is commonly used to help staff plan for the day ahead and to address challenges. However, most ward teams told us they were under too much pressure or too short-staffed to hold huddles consistently. Staff on AMSS said they tried to hold huddles daily dependant on staffing but during our inspection this did not happen, other than a brief discuss between the nurse in charge and a doctor to prioritise discharges.

Matrons and senior ward staff carried out periodic establishment reviews to monitor required staffing levels in line with patient dependency and to ensure vacancy rates were accurate. The most recent review on the stroke ward identified 6.7 WTE vacancies.

Vacancies amongst the AHP teams were significant. There were 2.6 WTE occupational therapists (OTs) to cover eight clinical areas and wards with vacancies at bands two, three and six. The service had focussed on developing and promoting staff internally to help sustain the service but a lack of external recruitment meant vacancies remained. The dietician team had worked short of staff for over 18 months and said there was a lack of qualified staff in the region. Therapies had recruited four OTs in 12 months and there was no band five provision in 2019 with four band six posts outstanding. This presented a significant challenged to the delivery and growth of the service.

A team of 2.5 WTE physiotherapists and two WTE therapy assistants provided care to patients across eight clinical areas. This included respiratory medicine and the acute cardiac unit as well as intensive care, paediatrics, gynaecology, surgery and outpatients. This was a substantial workload and staff said it placed continuous, relentless pressure on them. Therapy assistants attended board rounds to coordinate physiotherapy plans and implemented therapy care plans.

Physiotherapists led clinics in outpatients on weekday afternoons, which meant they often had to leave patients waiting in order to review urgent inpatient needs. The team had vacancies for four WTE staff, including a senior band seven physiotherapist.

Speech and language therapy (SaLT) was provided by another NHS trust through a service level agreement. During our inspection, trust therapy staff and the provider of the SaLT service told us it was critically short staffed and could not meet patient’s needs. After our inspection we asked the trust for more information on this because we had previously raised it as a concern. The trust said that 0.6 whole time equivalent (WTE) SaLT therapists were assigned to this hospital, which was not in line with national guidance from the British Society for Rehabilitation Medicine and the British Association of Stroke Physicians. The trust also noted that a significant increase in demand on SaLT from the head and neck cancer service had impacted provision and that availability of therapists to deliver dysphagia training to nurses was also below demand.

There were not enough nurses with non-intensive ventilation (NIV) competencies to safely provide care on ward 7B, a respiratory ward. During our weekend inspection there was no nurse on duty with NIV competencies, other than the nurse in charge, until after 3pm. However, one patient who needed NIV care had been admitted to the ward and the team would be required to admit further patients with NIV needs from the emergency department on demand. The ward was operating with three registered nurses instead of the planned five and an associate practitioner and trainee nurse associate were providing support. However, these staff were unable to administer medicines. This was indicative of on-going nurse shortages on ward 7B. For example, the ward frequently operated night shifts with only one permanent member of the nursing team, with other posts filled by agency nurses. Although the service had a standard operating procedure that meant it could not safely operate with fewer than four registered nurses on shift, on the day of our inspection one nurse had been redeployed to another ward, which left three nurses. This meant the nurse in
charge was responsible for the care of six patients in addition to their ward management duties. We spoke to staff about this who said they could escalate the situation to the site team, who were helpful, but had limited capacity to provide relief. For example, the site manager had told the nurse in charge they would need to remain on site indefinitely unless another NIV-trained nurse could be found for the night shift as colleagues from other trust sites were unwilling to transfer their shift. This was resolved by the end of our inspection, but it placed additional stress on staff and took them away from their care duties.

On one day of our inspection on ward 6A, a staff nurse was the nurse in charge with no other senior input immediately available. The service was operating short of one nurse and with 50% agency staff. The service would also be short of one HCSW for the late shift and by midday the nurse in charge had not been told who would fill this. The nurse in charge said the operational matron or site team had not been to visit the ward despite being aware of significant pressures. Nurses said they felt healthcare of older people (HCOP) was not seen as a priority compared with other specialities and that such shortages were accepted by the trust. Nurses said they regularly worked on a ratio to patients of 1:10, which meant they could deliver only essential care and patients therefore went without personal care, such as for hygiene. We did not see this in practice during our inspection and nurses said they did not always report this as an incident because they did not feel the trust was invested in recognising or resolving the issue.

Senior ward nurses acknowledged that it was sometimes necessary to redeploy staff to balance safety and skill mix in wards but said they were excluded from the decision-making process. On the ACU we found the site manager had redeployed one nurse to another ward, which meant there was a shortage of trained nurses on the unit to respond to an acute cardiac deterioration. Staff said they felt they had to comply and did not feel they had a voice to raise their concerns with the site team.

Nurse staffing in the chemotherapy suite was stable and to establishment and reflected a 50% increase in the established staffing level since November 2018. This enabled the unit to increase opening times to cover six days per week, from 8am to 6pm. Overall, 14.7 WTE staff provided care, including nursing staff, HCSWs and the reception team.

Nurse staffing in the endoscopy unit was planned to include two staff nurses per procedure room, two admitting nurses and two recovery nurses. This would allow at least one registered nurse for each clinical room. During our unannounced weekend inspection there was one recovery nurse supervising two rooms due to staff sickness. Support from the senior team and good working practices meant the team managed patient risk effectively.

The hospital had only one cardiac advanced nurse practitioner (ANP) and this individual would shortly leave their post. Staff said high workloads were leading to burn-out and increased turnover.

A team of 31 nurses, including two advanced practitioners, and 12 HCSWs provided care in the endoscopy unit. This included nine nurse endoscopists, three of whom were prescribers.

On IAC, the 24-hour nursing establishment was four nurses and two HCSWs and the ward manager was included in the numbers. This was insufficient for a busy unit with the need for very fast complex actions and a high turnover of patients. There were no supernumerary staff members to help coordinate care and flow. The stroke ward routinely worked short of one nurse and one HCSW. Staff said on HCSW was usually redeployed overnight, which left them short of two staff. The ward manager was not supernumerary and was not able to safely deal with hyperacute stroke admissions as well as running the ward and managing a case load.

Medical staffing

The service did not have enough medical staff in each specialty with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.
The service did not always have enough medical staff to keep patients safe.

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for medicine.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>27.2</td>
<td>38.2</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>111.9</td>
<td>128.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>62.8</td>
<td>69.0</td>
</tr>
<tr>
<td>Pan trust*</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Trust-wide</strong></td>
<td><strong>202.8</strong></td>
<td><strong>236.2</strong></td>
</tr>
</tbody>
</table>

* The trust informed us that some staff worked over multiple sites. These staff are included under ‘pan trust’ above.

From April 2017 to March 2018, the medical staffing rate within medicine was 85.9%. This was higher than the rate of 78.8% in the more recent period from April 2018 to February 2019.

Pilgrim Hospital reported the following WTE nursing staff numbers for the periods below for medicine. There are nine units within medicine so the five with the lowest fill rates have been included, along with the total for all nine units.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Cardiology inpatients</td>
<td>4.0</td>
<td>8.0</td>
</tr>
<tr>
<td>General medicine inpatients</td>
<td>13.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Respir medicine inpatients</td>
<td>7.0</td>
<td>9.0</td>
</tr>
<tr>
<td>Diabetes inpatients</td>
<td>10.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Clinical haematology inpatients</td>
<td>2.8</td>
<td>4.0</td>
</tr>
<tr>
<td><strong>Site total</strong></td>
<td><strong>62.8</strong></td>
<td><strong>69.0</strong></td>
</tr>
</tbody>
</table>

The medical staff did not always match the planned number on all shifts in each department.

From April 2017 to March 2018, the medical staffing rate within medicine at Pilgrim Hospital was 91.0%. This was higher than the rate of 75.6% in the more recent period from April 2018 to February 2019.

Figures higher than 100% indicate there were more WTE in post than originally planned.

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

The service had high vacancy rates for medical staff, with some specialties without any permanent or substantive doctors in post.

From April 2018 to March 2019, the trust reported a vacancy rate of 17.8% for medical staff in medicine. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Pilgrim Hospital medicine department: 17.6%

A breakdown of the five highest vacancy rates by ward is below:
<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical haematology inpatients</td>
<td>48.3%</td>
</tr>
<tr>
<td>Stroke inpatients</td>
<td>31.3%</td>
</tr>
<tr>
<td>Diabetes inpatients</td>
<td>25.8%</td>
</tr>
<tr>
<td>Respiratory medicine inpatients</td>
<td>21.3%</td>
</tr>
<tr>
<td>Cardiology inpatients</td>
<td>14.6%</td>
</tr>
</tbody>
</table>

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

Several wards and clinical areas worked with over 50% of medical staffing filled by locums.

The medical wards had three specialities consultants who offered seven day cover. These were stroke, cardiology and gastroenterology. Only the lead consultant worked cross site with Lincoln County hospital. Most clinical lead consultant posts were vacant, except diabetes and renal and care of the elderly.

From April 2018 to March 2019, the trust reported a turnover rate of 31.2% for medical staff in medicine. This was higher than the trust target of 8%. Turnover data for medical staff includes trainee grades which may have inflated the rate.

- Pilgrim Hospital medicine department: 36.4%

A breakdown of turnover rates by ward is below.

The service had high turnover rates for medical staff.

Eight of the nine medical wards had turnover recorded from April 2018 to March 2019. The five wards with the highest turnover are shown below:

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes inpatients</td>
<td>92.9%</td>
</tr>
<tr>
<td>Respiratory medicine inpatients</td>
<td>57.7%</td>
</tr>
<tr>
<td>Cardiology inpatients</td>
<td>44.0%</td>
</tr>
<tr>
<td>Stroke inpatients</td>
<td>35.6%</td>
</tr>
<tr>
<td>General medicine inpatients</td>
<td>31.9%</td>
</tr>
</tbody>
</table>

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

Sickness rates for medical staff were low.

From April 2018 to March 2019, the trust reported a sickness rate of 1.7% for medical staff in medicine. This was lower than the trust target of 4.5%.

- Pilgrim Hospital medicine department: 1.3%

A breakdown of the five wards with the highest sickness rates is shown below.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory medicine inpatients</td>
<td>4.4%</td>
</tr>
<tr>
<td>Cardiology inpatients</td>
<td>2.7%</td>
</tr>
<tr>
<td>Diabetes inpatients</td>
<td>1.0%</td>
</tr>
<tr>
<td>Gastroenterology inpatients</td>
<td>0.6%</td>
</tr>
<tr>
<td>Clinical haematology inpatients</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
The service had substantial rates of bank and locum staff used on the wards. Managers could not always access locums when they needed additional medical staff and there were substantial shifts uncovered by medical staffing.

Managers made sure locums had a full induction to the service before they started work.

Please note that the trust confirmed that they were unable to provide accurate establishment hours by department and location in all cases. Therefore, we have not calculated the proportion of hours filled by bank and locum staff or left unfilled as this may be misleading.

The table below shows the number of medical hours in medicine by site from April 2018 to February 2019 that were covered by bank and locum staff or left unfilled.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2018 to March 2019</th>
<th>Bank usage</th>
<th>Locum usage</th>
<th>Not filled by bank or locum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital</td>
<td></td>
<td>18,496</td>
<td>54,357</td>
<td>6,028</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>34,994</td>
<td>151,453</td>
<td>15,843</td>
</tr>
</tbody>
</table>

Over this time period, 34,994 hours were filled by bank staff and 151,453 hours were covered by locum staff to cover sickness, absence or vacancy for medical staff. The trust was unable to fill 15,843 of the available hours with either bank or locum staff.

The table below shows the number of medical hours in medicine at Pilgrim Hospital from April 2018 to February 2019 that were covered by medical and locum staff or left unfilled.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2018 to March 2019</th>
<th>Bank usage</th>
<th>Locum usage</th>
<th>Not filled by bank or locum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td></td>
<td>11,424</td>
<td>17,746</td>
<td>3,492</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td></td>
<td>4,399</td>
<td>9,240</td>
<td>506</td>
</tr>
<tr>
<td>Care of the Elderly</td>
<td></td>
<td>225</td>
<td>7,647</td>
<td>356</td>
</tr>
<tr>
<td>Haematology</td>
<td></td>
<td>0</td>
<td>5,797</td>
<td>348</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td></td>
<td>433</td>
<td>3,712</td>
<td>300</td>
</tr>
<tr>
<td>Core service total</td>
<td></td>
<td>18,496</td>
<td>54,357</td>
<td>6,028</td>
</tr>
</tbody>
</table>

Over this time period, 18,496 hours were filled by bank staff and 54,357 hours were covered by locum staff to cover sickness, absence or vacancy for qualified nurses. The trust was unable to fill 6,028 of the available hours with either bank or locum staff.

The five departments with the highest numbers of combined bank, locum and unfilled hours are shown.

In January 2019, 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 the same.

Staffing skill mix for the 200 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>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>14%</td>
<td>7%</td>
</tr>
</tbody>
</table>
The service always had a consultant on call during evenings and weekends. During our weekend inspection two doctors were assigned to support patient flow in medical wards. This followed consultant-led ward rounds in each specialty except for oncology.

Gaps in medical staffing in oncology and haematology meant consultant ward rounds took place only once each week and there was no formal medical handover process in place. At other times, trainee doctors carried out ward rounds and discussed plans with consultants elsewhere in the trust on an as-needed basis. This meant there was no formalised or standardised handover process.

Junior doctors were generally positive about working in the hospital and their support and workload. On the ACU a junior doctor said consultant cover was consistent and they rarely used locum doctors. However, junior doctors described on-call shifts as “erratic”. For example, at weekends they covered seven medical wards with a single consultant and said ward rounds took up to six hours to complete. This meant clinical tasks were delayed for several hours.

A team of eight WTE consultants, four specialist registrars (SpRs), two WTE locum doctors and one WTE agency doctor provided medical care in oncology and chemotherapy. One foundation level doctor worked between oncology and haematology. The team worked cross-site and provided variable levels of cover at this hospital, including for outpatients, from Monday to Thursday only. In addition, there were three WTE vacancies in the consultant team due to unfilled posts and sickness. The trust had recently appointed a new advanced care practitioner to support care delivery in oncology.

Overnight on-call cover for the medical wards consisted of one middle grade doctor (grade ST3) from 9pm, one junior doctor based in the IAC and one junior doctor to cover all medical wards. A general medicine consultant was on-call from home for advice and one consultant for each of stroke, cardiology and gastroenterology bleed was on call from home.

The endoscopy unit had recruited four new endoscopists to reduce the reliance on agency staff. This would ensure one permanent member of staff was always available per patient list.

Four substantive consultants and four locum consultants led care on the AMSS and integrated assessment centre (IAC). There was always a senior decision-maker available in this service, with some overnight cover provided by middle grade doctors.

Doctors recruited from international programmes had documented appraisals and named clinical supervisors.
The IAC was set up in October 2018 as a combined acute receiving unit for orthopaedics, surgery, urology and medicine. The unit had eight consultants, four of whom were permanent and four were locums. Consultants were not always aware of planned medical staffing levels. For example, during our inspection a locum consultant arrived in the ward unexpectedly. The consultant in charge assumed they had worked in the department before because of the manner in which they used the staff room. This was not a robust system and we were not assured medical staffing was well coordinated.

Junior doctors in IAC were organised into a clerking team, adjusted to match the profile of daily admissions. Junior staff from AMSS helped with pressures, such as on one day of our inspection when there were 13 patients not clerked from the night shift. In addition, there were six patients with delayed clinical management and care plans due to misunderstandings amongst the medical team. Although locum doctors had requested input from medical specialties, there were no formal requests for referral. Some patients were therefore left in limbo with nobody in charge. We escalated this as a matter of urgency to the nurse who charge.

Out of hours staffing on the IAC was not appropriate. Between 5pm and 9am and at all times at weekends, one SpR covered three areas at the same time; IAC, emergency department resuscitation, and medical ward emergencies. A single trust grade doctor covered the wards. A second trust grade doctor was based in IAC clerking patients and also taking all referrals for admission.

There were significant differences in staff understanding of the levels of consultant review at weekends. For example, during our weekday inspection, doctors told us specialist consultant review of patients at weekends happened for haematology, oncology and stroke, but said the other specialties relied upon the on-call general team seeing patients on demand. However, during our weekend inspection we found consultant review had taken place in all specialties except oncology.

The hospital provided a continuous consultant-led hyperacute thrombolysis service. Of the four consultants, one was substantive and three were long term locums, one of whom started in March 2019. There were no SpRs in the service and three junior doctors provided support.

Two consultants, one of whom was substantive, carried out daily ward rounds, except for Saturdays, in haematology. The team worked on a shared on-call rota with four haematologists based at Lincoln County Hospital, specifically for haematology patients. A core trainee doctor worked between haematology and oncology services and covered the chemotherapy suite.

Seven consultant oncologists worked between this hospital and Lincoln County, although one consultant was unavailable on a long-term basis. Four SpRs worked on rotation to carry out ward rounds and deliver care in the chemotherapy suite.

There were no substantive consultants in the stroke service. Two long-term locum consultants primarily delivered care. Senior nurses did not know which doctors were locums and whether or not there was a clinical lead in post.

**Records**

_Staff kept detailed records of patients’ care and treatment. Records were mostly clear, up-to-date and easily available to all staff providing care._

Patient notes were comprehensive, and all staff could access them easily. We reviewed a sample of eight nursing assessments completed on admission and found they included all necessary information to provide immediate, safe care.
Staff used interactive touch-screen electronic boards to track patient's needs. It was not common practice for staff to lock these boards, although they were located in areas usually occupied by staff. However, on ward 8A, we observed a patient touching the screen, which presented a risk they could access confidential information.

When patients transferred to a new team, there were no delays in staff accessing their records. Records were not always stored securely. For example, we saw staff in AMSS and on ward 8A, did not always lock notes trolleys when they were not in use. We found loose, printed patient records on unattended desks in wards 7B and 8A on all days of our inspection. On AMSS, Lockable cabinets to store patient records were not always locked when staff were not using them. Code combinations had not been changed in over six months, since the cabinets started being used. This presented a security risk in light of the large number of temporary staff who passed through the department.

On ward 8A some medical entries were not signed or dated. Other staff had noted retrospectively these needed to be signed and dated but this had not occurred.

**Medicines**

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when prescribing and storing medicines. Staff told us that there was a pharmacy service to the wards although in some cases this was not sufficient to meet the needs of the service. This led to medication charts needing to leave wards to allow patient-specific medicines to be dispensed. This meant that they were not readily available for ward rounds or medicine rounds.

Staff did not always complete the necessary documentation to demonstrate safe prescribing. We saw gaps in documentation for patients who managed their own medicine, which resulted in a lack of assurance this was appropriate in line with trust policy.

We saw instances of medicines being omitted without any reasons documented. This was the case in four out of 37 records we checked.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. Information on the medicine administration charts demonstrated that antibiotics and other medicines were reviewed in line with trust policy. Patients told us they received information about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. We saw evidence of appropriate storage of medicines. We reviewed medicine storage practices on wards 6A, 6B, 7A and the ACU. Staff had consistently recorded the temperatures of rooms and fridges used to store medicine. However, there was no evidence staff on ward 6B had taken action when fridge temperatures had exceeded the manufacturer’s maximum recommended limit.

Staff stored and managed Controlled Drugs (CDs) in line with national best practice guidance. This included double-signing of administration and secure, controlled storage. Staff on ward 6A had not always documented changes to the current page in the CD book on the medication box. Although stock levels were accurate, noting page changes ensures staff always have access to the most up to date records available.
Staff followed current national practice to check patients had the correct medicines. We saw evidence of timely medicines reconciliation by pharmacy staff and saw this in action to prevent medication being missed.

Staff told us that to take away (TTO) medicine may be delayed due to the timing of pharmacy staff visiting the wards. On ward 6A, pharmacy staff told us they were not allocated enough time to complete all tasks and we saw that a patient was prescribed a dose of enoxaparin outside of trust policy for 9 days before pharmacy staff identified the error.

There was no documented evidence that staff in the ACU carried out a handover check between shifts of patients who received medicine through a syringe driver. Staff had otherwise followed best practice, including documented drug chart updates every 24 hours by two nurses.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Chemotherapy was a nurse-led service and all nurses had training in the use of patient group directions (PGDs) for painkillers and antibiotics. The team was also trained to manage anaphylactic reactions. PGDs enable trained staff to administer certain medicines to patients within defined circumstances.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff were aware of safety alerts and recalls and described a process for feedback of their actions taken.

Decision-making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed the notes of three patients who had been chemically sedated. In each case staff had followed established protocols to ensure they acted in the patients’ best interests.

Staff on two wards described a process for handling recalls and alerts that involved feeding back their actions to matrons.

Staff described the process for raising an incident report on medicines incidents and could describe actions taken across the trust following incidents.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. However, the trust did not supply a record of incidents in a format we could fully analyse. This meant we had limited oversight of standards of reporting over the previous 12 months.

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

From March 2018 to February 2019, the trust reported no never events in medicine.

(Source: Strategic Executive Information System (STEIS))

Staff reported serious incidents clearly and in line with trust policy.
In accordance with the Serious Incident Framework 2015, the trust reported 86 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from March 2018 to February 2019.

Breakdowns of the serious incidents by type and trust site are shown in the tables below:

### Incident type

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>48</td>
<td>55.8%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>20</td>
<td>23.3%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>8</td>
<td>9.3%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>4</td>
<td>4.7%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>4</td>
<td>4.7%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Trust-wide</strong></td>
<td><strong>86</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Site name

<table>
<thead>
<tr>
<th>Site name</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Boston Hospital</td>
<td>43</td>
<td>50.0%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>39</td>
<td>45.3%</td>
</tr>
<tr>
<td>Grantham District Hospital</td>
<td>4</td>
<td>4.7%</td>
</tr>
<tr>
<td><strong>Trust-wide</strong></td>
<td><strong>86</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

In accordance with the Serious Incident Framework 2015, Pilgrim Hospital reported 43 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from March 2018 to February 2019:

### Incident type

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>28</td>
<td>65.1%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>7</td>
<td>16.3%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>4</td>
<td>9.3%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>2</td>
<td>4.7%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
<td>2.3%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>2.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>43</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff had documented appropriate use of the duty of candour in the incident reports we looked at.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was limited evidence that changes had been made as a result of feedback.

We reviewed the investigations of the most recent SIs reported in medicine and found common themes throughout each incident. This included delays in clinical investigations, examination of symptoms, failure to document examination and a failure to escalate concerns, complete risk assessments and to carry out handovers. Incident reports found gaps in nursing assessments and
a lack of adherence to established, readily-available care pathways and policies, such as the SSKIN bundle. Incidents also identified staff had failed to escalate deteriorating patients to the on-call team and had not carried out observations at appropriate frequencies even when they knew patients were deteriorating. Each investigation included an action plan, with clear accountability for completion. There was also evidence findings were distributed appropriately. However, there was limited evidence action taken was effective or prevented future recurrences.

Between January 2019 and June 2019, medical care services reported three incidents that resulted in severe harm or death. The patient death occurred following a failure of staff to follow critical safety and care pathways, including a failure to administer antibiotics and a poor response from the medical on-call team. The incident occurred in February 2019 yet remained under investigation as of July 2019. Another incident that resulted in serious harm involved a failure to accommodate a rapidly deteriorating patient and inadequate response from the critical care team. Both incidents occurred in healthcare for older people services. We saw the themes in the incident causes and investigations recurred commonly in the hospital across multiple services.

There were a number of strategies and programmes in place to address the need for learning from incidents, this included more consistent practice in relation to preventing falls and pressure ulcers. We saw evidence of this in wards and staff were knowledgeable although data supplied by the trust indicated limited impact to date.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. However, staff in several areas told us they no longer reported incidents that resulted from short staffing.

The respiratory ward had 210 open incidents, some of which were over two years old. We spoke with the acting ward manager about this who had implemented an action plan shortly before our inspection. They attributed the backlog and delays to frequent changes of leadership, including multiple secondments. Senior staff were unable to confirm if the backlog had impacted compliance with the duty of candour and whether appropriate learning had taken place. The new ward manager had implemented an incident management strategy to ensure new reports were reviewed within the trust target of 72 hours and the duty of candour implemented.

Managers debriefed and supported staff after any serious incident.

A scrutiny panel was investigating pressure ulcers in the stroke unit and found documentation with patients admitted from the community did not always identify existing pressure area risk. The team implemented twice-daily safety huddles to increase awareness of patients at risk. The team found patients would often decline repositioning without understanding the risks of not being turned. To address this, they worked with staff to improve their understanding of the Mental Capacity Act (2005) and how they could better support and understand patients.

Staff had implemented a range of interventions to reduce falls risks based on the incident rate. This included providing patients with non-slip socks, more consistency in falls risk assessments and more frequent decluttering of ward areas.

The tissue viability team had implemented more robust standards for the completion of the SSKIN tool to prevent hospital-acquired pressure ulcers. SSKIN refers to a national standard of skin care documentation. The team reviewed all incidents relating to pressure ulcers and care.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.
Safety thermometer data was displayed on wards for staff and patients to see.

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.

Staff used the safety thermometer data to further improve services.

Quality matrons used the safety and quality dashboard to monitor safety performance on each ward. This included an assessment of care standards for falls assessment, tissue viability, fluid management, nasogastric feeding, medication, high impact care bundles and consistency of senior staff reviews of patients. Wards displayed the data on a rolling basis along with initiatives and action plans for improvement.

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 35 new pressure ulcers, 14 falls with harm and eight new urinary tract infections in patients with a catheter from March 2018 to March 2019 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter UTIs at United Lincolnshire Hospitals NHS Trust**

1. Total Pressure ulcers (35)
   - Prevalence rate
   - (35)

2. Total Falls (14)
   - Prevalence rate
   - (14)

3. Total CUTIs (8)
   - Prevalence rate
   - (8)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)
Nurses used ‘intentional rounding’ to review the safety and needs of patients at predetermined frequencies. We reviewed a sample of five intentional rounding records and found staff had completed them consistently. This included a record of turns and other patient needs in relation to high impact therapy measures such as catheter care bundles.

The senior team on ward 6A had implemented an action plan to improve monthly compliance with the national Saving Lives care bundle. This was based on monthly audits used to identify and resolve safety risks.

Staff on ward 8A had introduced new escalation standards for patients with pressure areas, including referrals to a dietician and tissue viability nurse and documentation from a medical photographer.

The IAC ward manager introduced a sequential system of high focus to improve care and safety in relation to falls, tissue viability, preventing sepsis, observations, all safety quality data, and the avoidance of chemical sedation in the elderly and confused. They discussed these areas during team meetings, handovers and safety huddles.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Specialist staff supported teams across the hospital to achieve this. For example, a sepsis lead practitioner worked with nurses during their induction period and routinely to assist them in following National Institute of Health and Care Excellence (NICE) guidance.

Staff used an audit programme to establish standards of care and to benchmark patient outcomes against trust and national standards. In 2018/19 there were 11 audits in progress and a NICE and best practice coordinator supported audits that were used to establish baseline performance against national standards. Most audits found standards to be variable across wards with a need for better staff training and understanding. This included the completion of fluid balance charts, oxygen prescribing standards and use of the do not attempt resuscitation (DNACPR) tool.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

The tissue viability team worked with ward staff to coordinate card for patients at risk of pressure areas and reduced skin integrity. They monitored this work through mattress audits, the ward accreditation programme and incidents. Quality matrons supported this work and worked with wards at increased risk.

The respiratory service had strengthened the care pathway for non-invasive ventilation through the use of an evidence-based proforma for trained nurses to follow. This enabled staff to provide safe care for patients who were classified as level 2 on the Intensive Care Society scale, which denoted a high level of dependency.
The endoscopy unit was accredited by Joint Advisory Group (JAG) on GI Endoscopy. This meant the team had demonstrated consistent care, quality and safety in line with national standards. The unit was a regional training centre for endoscopy staff working in other services.

The tissue viability team aimed to respond to referrals within 48 hours although there was no audit or monitoring system in place for this.

The AHP team led an audit programme to assess standards of care and provide benchmarking data to help the team understand their strengths and areas for improvement. In 2018/19 the team completed nine audits, which included specific audits for the on-call respiratory physiotherapy service and to measure standards in line with record keeping and consent guidance issued by the NHS Litigation Authority.

In 2018 the stroke team completed a comprehensive action plan to improve patient safety through more consistent, higher quality documentation and patient care. This included a more responsive approach to the deteriorating patient and the introduction of neurology training or all registered nurses in the service.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The dietetics team worked closely with the catering manager to ensure cost pressures on the trust did not result in reduced quality of nutrition for patients. The team worked together to ensure foods available had the appropriate nutritional composition and were readily available to patients when they needed it. In the 2018 patient-led assessment of the care environment (PLACE), inpatient medical care scored 89%. This was similar to the national average score of 90%.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. We reviewed a sample of notes and checklists, including two nasogastric (NG) tube bedside checklists, SSKIN checklists, feed change records, fluid balance and oral care bundles of 13 patients in four inpatient wards. In each case we saw staff had fully completed and documented observations.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All nurses and some healthcare support works (HCSWs) were trained in the use of this tool and dieticians and speech and language therapists (SaLTs) monitored consistency.

Specialist support from staff such as dieticians and SaLTs was available for patients who needed it. Clinical staff used an electronic system to refer patients to the dietician and SaLT teams for more complex needs, such as total parental nutrition (TPN). Dieticians maintained up to date policies and care guidelines, including an NG feeding policy and an escalation policy for feeding problems with patients with complex needs.

We spoke to eight patients who all told us they were offered enough liquids. During our observations on wards we saw patients had water or juice within reach and staff supplied adapted cups, such as with straws or spouts.

We observed the lunch service on the acute medical short stay (AMSS) unit and on wards 6A and 6B. Staff had a good understanding of each patient’s needs and clearly communicated special meals and who would require support to eat. Patients who required one-to-one support to eat had their meal served last so that it stayed hot in the service trolley until staff were ready to assist.
However, on the AMSS we saw one member of staff gave a patient their lunch then collect it untouched 30 minutes later without asking if they needed help.

Dieticians carried out lunchtime spot checks on inpatient wards to check the standard of nutrition support patients received. This included the speed of service and the temperature and texture of food.

Clinical staff used an emergency regime for feeding tubes for patients when dieticians were not on site at weekends. The team then prioritised these patients for review on a Monday morning.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded all pain relief accurately.

The trust had disbanded the dedicated pain team and there was a lack of information available to ward staff about alternatives. Senior staff told us the trust had outsourced the service, but the contractor had a staff shortage, which meant there was no service operational in the hospital. Clinical teams used established pathways to manage pain, but the absence of a dedicated team meant there was no acute or chronic pain service available.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The service participated in relevant national clinical audits. The service performed well in national clinical outcome audits and managers used the results to improve services further.

From December 2017 to November 2018, patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

Of the top three specialties by number of admissions:
- Patients in clinical oncology had a similar to expected risk of readmission for elective admissions to the England average
- Patients in medical oncology and clinical haematology had lower than expected risks of readmission for elective admissions

**Elective Admissions – Trust Level**

![Graph](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top*
From December 2017 to November 2018, patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Patients in general medicine, cardiology and clinical oncology had lower than expected risks of readmission for non-elective admissions.

**Non-Elective Admissions – Trust Level**

![Graph showing non-elective admissions by specialty](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 represents the opposite. Top three specialties for specific trust based on count of activity.*

(Source: Hospital Episode Statistics - HES - Readmissions (01/12/2017 - 30/11/2018))

From December 2017 to November 2018, patients at Pilgrim Hospital had a similar to expected risk of readmission for elective admissions when compared to the England average.

Of the top three specialties by number of admissions:
- Patients in medical oncology and clinical haematology had lower than expected risks of readmission for elective admissions
- Patients in clinical oncology had a higher than expected risk of readmission for elective admissions

**Elective Admissions - Pilgrim Hospital**

![Graph showing elective admissions by specialty](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 represents the opposite. Top three specialties for specific site based on count of activity.*

From December 2017 to November 2018, patients at Pilgrim Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Of the top three specialties by number of admissions:
- Patients in general medicine and medical oncology had lower than expected risks of readmission for non-elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for non-elective admissions

**Non-Elective Admissions - Pilgrim Hospital**
Pilgrim Hospital takes part in the Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in the latest audit, covering the period from October to December 2018. Over the last four audits the trust consistently achieved grade B.

**Team centred performance**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Dec 17 - Mar 18</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
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<td>B↓</td>
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<td>Domain 5: Occupational therapy</td>
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<td>Domain 6: Physiotherapy</td>
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<td>B</td>
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<tr>
<td>Domain 7: Speech and language therapy</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Team-centred total key indicator level</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
</tr>
</tbody>
</table>

**Overall Scores**

<table>
<thead>
<tr>
<th></th>
<th>Dec 17 - Mar 18</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>

(Source: Royal College of Physicians London, SSNAP audit)

We spoke with the stroke team about the downgrade in performance, from an A grade to a B grade. They recognised the decline was due to a lack of capacity in the computed tomography (CT) service, which meant wait time for scans routinely exceeded one hour with delays of over four hours in a ward transfer.
The table below summarises the trust’s performance in the 2017 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td>6.4%</td>
<td>Does not meet the audit aspirational standard</td>
<td>✗</td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate (Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>36.1%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>16.5%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment (For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>49.8%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>57.7%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
</tbody>
</table>

(Source: National Lung Cancer Audit)
The table below summarises Pilgrim Hospital’s performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>Yes</td>
<td>n/a</td>
<td>✓</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) (Having a vision assessment is indicative of good practice in falls prevention)</td>
<td>0.0%</td>
<td>Red</td>
<td>❌</td>
</tr>
<tr>
<td>Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) (Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)</td>
<td>88.9%</td>
<td>Green</td>
<td>❌</td>
</tr>
<tr>
<td>Crude proportion of patients assessed for the presence or absence of delirium (if applicable) (Having an assessment for delirium is indicative of good practice in falls prevention)</td>
<td>68.8%</td>
<td>Amber</td>
<td>❌</td>
</tr>
<tr>
<td>Crude proportion of patients with a call bell in reach (if applicable) (Having a call bell in reach is an important environmental factor that may impact on the risk of falls)</td>
<td>100.0%</td>
<td>Green</td>
<td>✓</td>
</tr>
</tbody>
</table>

(Source: National Audit of Inpatient Falls)
The table below summarises Pilgrim Hospital’s performance in the 2018 Chronic Obstructive Pulmonary Disease Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit's Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen by a member of the respiratory team within 24hrs of admission? (Specialist input improves processes and outcomes for COPD patients)</td>
<td>58.0%</td>
<td>Worse than the national aggregate</td>
<td>✗</td>
</tr>
<tr>
<td>Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) (Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)</td>
<td>100.0%</td>
<td>Better than the national aggregate</td>
<td>✓</td>
</tr>
<tr>
<td>Percentage of patients receiving non invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival (NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</td>
<td>Not available</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy (Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</td>
<td>Not available</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (Completion of a discharge bundle improves readmission rates and integration of care)</td>
<td>84.2%</td>
<td>Better than the national aggregate</td>
<td>✓</td>
</tr>
<tr>
<td>Percentage of patients with spirometry confirming FEV1/FVC ratio &lt;0.7 recorded in case file (A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt)</td>
<td>41.4%</td>
<td>Better than the national aggregate</td>
<td>✗</td>
</tr>
</tbody>
</table>

(Source: Chronic Obstructive Pulmonary Disease Audit)
The table below summarises Pilgrim Hospital’s performance in the 2017 National Audit of Dementia.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good (A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</td>
<td>No data available</td>
<td>n/a</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of staff responding “always” or “most of the time” to the question “Is your ward/ service able to respond to the needs of people with dementia as they arise?” (This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</td>
<td>75.0%</td>
<td>Middle 50% of hospitals</td>
<td>No current standard</td>
</tr>
<tr>
<td>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium (Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</td>
<td>43.9%</td>
<td>Middle 50% of hospitals</td>
<td>No current standard</td>
</tr>
<tr>
<td>Multi-disciplinary team involvement in discussion of discharge (Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</td>
<td>65.3%</td>
<td>Bottom 25% of hospitals</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Audit of Dementia)

Managers used information from the audits to improve care and treatment. This took place variably depending on the medical specialty. For example, specialties without a clinical lead or dedicated audit nurse did not use the data as consistently as services with more permanent staff. This was evident in the respiratory service, which performed poorly in the national COPD audit for specialty review. Although staff were aware of the need for improved performance, significant staffing shortfalls meant opportunities for this were limited. In HCOP services, staff used results from the National Audit of Dementia to improve how they responded to the needs of patients living with dementia.

Not all medical specialties had engagement meetings and/or follow-up of audit outliers. For example, the respiratory service did not have an active programme in place to review NIV times and HCOP did not formally collect data from carers about their experience in the hospital.
Managers did not always share and make sure staff understood information from the audits. Improvement was not always checked and monitored. This varied between medical specialties and was impacted by staff shortages. For example, wards with high numbers of agency and locum staff were unable to consistently share audit outcome data in the same way as wards with more permanent staff.

Allied health professionals (AHPs) worked proactively with a range of community partners to improve outcomes for patients. For example, they had invited staff from a day centre into the hospital to join board rounds and multidisciplinary meetings to help them plan more individualised care for patients after discharge. Day centres typically provide planned programmes and opportunities for social activities for patients with a range of needs that cannot be met at home. This work also helped community therapists to build exercise and rehabilitation programmes that more seamlessly reflect those established in the hospital.

We looked at a sample of five patient’s records on AMSS and found in each case the service had met the target for no more than 14 hours between admission and first consultant review.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced and qualified but did not always have the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work.

From April 2018 to February 2019, 75.9% of staff within medicine department at the trust received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>110</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>24</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>90</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>449</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>8</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>336</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>5</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>0</td>
</tr>
</tbody>
</table>
From April 2018 to February 2019, 75.7% of staff within medicine department at Pilgrim Hospital received an appraisal compared to a trust target of 95.0%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>123</td>
<td>161</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>120</td>
<td>177</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers did not always support nursing staff to develop through regular, constructive clinical supervision of their work. This was reflected in the low completion rates of appraisals. This was impacted by persistent short staffing in a number of specialties, which meant pressures on nursing teams reduced time available for appraisals. However, nurses in the endoscopy unit and the chemotherapy suite had more consistent access to appraisals and supervision.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors confirmed this in our discussions but said access to consultant-led supervision was highly variable because of the reliance on locum consultants, who did not usually provide the same level of supervision as a permanent doctor.

There were not enough clinical educators to support staff learning and development. Staff said access to educators was variable and although the team was on site regularly, it was often difficult to secure time with them.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. This was the case where services had a meeting schedule. However, not all specialties regularly arranged staff meetings and the trust did not have an established standard for this.

Staff had limited opportunities to discuss training needs with their line manager and were not always supported to develop their skills and knowledge. This was the result of high levels of short staffing in most services. However, staff in the endoscopy unit and the chemotherapy suite had significantly better, more consistent training and skills development opportunities.

Managers did not always make sure staff received specialist training for their role and there were shortages of trained staff in some specialties. For example, only five respiratory nurses were trained in NIV care and the service had to operate 24-hours, seven days a week despite this.

Managers identified poor staff performance promptly and supported staff to improve. For example, senior staff followed trust policy when staff needed support or guidance to address performance issues. All of the staff we spoke with said they felt such processes were fair and proportionate.

A dedicated volunteer services manager recruited, trained and supported volunteers to support patients in the service. Processes were well-established and robust and meant volunteers had structured support and access to appropriate training.
The sepsis practitioner worked across the hospital to improve staff training. At the time of our inspection 90% of relevant staff had completed this training. The practitioner had established link nurses on ward 7B to help nurses screen for sepsis appropriately amongst patients diagnosed with chronic obstructive pulmonary disease (COPD). They had also worked with the integrated assessment centre (IAC) team to increase sepsis screening compliance from 40% to 85%.

Tissue viability nurses worked with healthcare support workers (HCSWs) to improve their practice when turning patients and helping them to mobilise. The team also led sessions during nurse preceptorship courses and carried out ad-hoc observations on wards to assess standards of practice. The trust did not offer or mandate robust training for medical staff on tissue viability and the specialist team offered prevention training for medical staff although they said uptake was variable.

Staff on each ward who specialised in areas, such as sepsis or dementia care, prepared high-impact, colourful information and education boards for their team. This included information on national best practice guidance as well as the ward’s latest achievements in line with these. For example, education boards on ward 6A identified 100% compliance with sepsis screens within 60 minutes of arrival.

AHPs maintained up to date competencies in line with relevant national standards, including specific competencies for rehabilitation and the use of specialist equipment. However, most staff we spoke with were highly critical of the trust’s approach to training and development. For example, one member of staff said, “We have no time to do anything other than the basics of our job.” Another member of staff said the trust had reduced their training budget to such an extent that none of the team could attend any external training courses. The team said they persevered by finding free online courses and shadowing more senior staff, but it was evident this was not a sustainable, long-term solution.

AHPs, such as physiotherapists and dieticians, worked across medical wards based on their experience and areas of expertise. For example, senior dieticians focused their work on specialist wards and staff-grade dieticians worked across general medicine.

Junior doctors said they received timely supervision and appraisals in areas that had permanent consultant presence. In other areas, feedback was variable as locum consultants did not provide the same degree of supervision as permanent colleagues. Junior doctors had access to scheduled teaching, typically for one hour once per week. A grand round took place weekly although doctors said they were not always able to attend this due to workload. The consultant rota was top-heavy with locums, which did not encourage an atmosphere which covered all of the issues relevant to the junior doctor in training. Systematic learning was not enhanced and doctors found it difficult to get signed off for observed procedures for their portfolio. There was little evidence of vigour behind potential audit and research projects, and the status quo was not subject to sufficient challenge. Junior doctors did not have a forum for staff in training to contribute ideas and feedback to the management and educational process, or to air concerns for resolution or mutual support.

Staff in the endoscopy unit said they had time for training and development opportunities and some staff had completed an endoscopic retrograde Cholangio-Pancreatography (ERCP) study day.

Two diabetes link nurses worked on ward 8A and were supported by the hospital lead diabetes nurse, who visited the ward monthly on planned dates.

Senior AHPs visited teaching programmes at other providers to adapt good practice to this hospital. The team had developed a series of videos for trainees and junior staff to use to develop their practice.
The deputy sister for chemotherapy was a clinical nurse educator and provided dedicated chemotherapy study days for staff, including those who worked in the inpatient oncology ward.

The dedicated local computed tomography (CT) training programme did not meet the needs of staff who said around 50% of courses were cancelled without notice. This discredited the programme and reduced the drive to attend.

Short staffing in the SaLT service meant 78% of patients known to the service did not have a follow-up review prior to discharge.

The authorising decontamination engineer for endoscopy found a number of gaps in training in for staff during a visit in May 2018. They made four key recommendations to access specialist training opportunities.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Clinicians, AHPs and community social care staff worked together to coordinate packages of care and safe discharges.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, AHPs worked across acute, emergency, specialist and general medicine and provided support to surgical wards. Physiotherapists, occupational therapists (OT), SaLTs and dieticians delivered highly coordinated, individualised care. The team screened all referrals although there was no system in place to reduce inappropriate referrals, which the team said happened frequently from wards with transient staffing. This meant staff saw patients who did not need AHP input, which delayed care for patients who did need review or treatment.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Patients had their care pathway reviewed by relevant consultants and other specialists. This included multidisciplinary ward rounds attended by appropriate specialists, such as OTs, physiotherapists and consultants.

We found good standards of multidisciplinary working in clinical departments and wards, but this was not matched when patients needed input from specialist teams based elsewhere. For example, one patient on ward 6A had waited several days for a review by the respiratory team. A physiotherapist had carried out aspirational arterial blood gas (ABG) checks on the patient, but care could not progress without a further review. We spoke to clinical staff about this who said it was common to wait several days for a review from some specialist teams due to workload and short-staffing.

Shortages in the physiotherapy team meant a single therapist attended daily board rounds for wards 6A and 6B, which overlapped in time. We observed this process and saw the physiotherapist provided consistent, high quality input into patient planning despite a highly challenging situation where they needed to be present in two places at the same time.

We observed excellent examples of care planning by a physiotherapist in ward 6B. The medical team had been unable to coordinate a structured plan for the patient’s discharge due to increasingly complex therapy and social care needs and the physiotherapist had prepared a detailed plan that included the tissue viability team.
On most inpatient wards, a daily board round took place with all of the consultants and junior doctors, plus therapists, a dietitian, the nurse in charge, SALT, ward clerk, adult social care staff and a discharge coordinator. This process was reduced at weekends to prioritise new patients and those who were acutely unwell.

Staff described excellent working relationships with lung cancer specialist nurses, Macmillan nurses and the palliative care team.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends, except for the oncology ward. Patients were reviewed by consultants depending on the care pathway and clinical need.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The discharge lounge was open seven days a week to support flow through the wards.

On-call physiotherapists, including specialist chest physiotherapists, and OTs provided an out of hours on-call service.

Consultants in most medical specialties provided a seven-day service. This included weekend ward rounds for sick patients and an on-call service when nurses or junior doctors escalated patients who were deteriorating.

The dietetics service operated from 8.15am to 6pm Monday to Friday, with no overnight or weekend cover.

The endoscopy unit was open seven days a week, including bank holidays, until at least 6pm.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every ward and unit. This included the national PJ Paralysis project, which encouraged patients to establish a daily routine on the ward that avoided spending excessive time in bed. Staff on wards demonstrated a positive attitude to this campaign and we saw teams supported patients to get out of bed every day and make the use of facilities such as day rooms and showers. This was an evidence-based campaign used to promote faster recovery and a lower dependence on nursing staff.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Staff had an acute awareness of the health inequalities and challenges in the local population, including poverty and drug dependency. They actively worked with community non-profit organisations to refer patients to them for continuing support and to avoid future readmission.

The tissue viability team took part in the annual, national Stop the Pressure day to raise awareness of good practice to maintain skin integrity. As part of this work, the team recognised wards that were consistently free from hospital-acquired pressure sores.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient’s consent. They did not always know how to
support patients who lacked capacity, or who were experiencing mental ill health, to make their own decisions. They used measures that limited patients’ liberty appropriately.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care when they presented with complex psychological needs. For example, we found conflicting notes and gaps in capacity assessments for one patient who presented with a high risk for suicide and self-harm. Although the mental health liaison team had reviewed the patient, there was a seven-day delay in completing a mental capacity assessment, which needed to be completed immediately. Although the patient had a learning disability, staff had not referred them to the learning disability specialist nurse. We escalated this during our inspection, which resulted in an immediate review. We were not assured the ward team had an adequate understanding of the capacity assessment process. In another example, staff had not completed a risk assessment for a patient known to experience fluctuations in capacity. This meant the team were unable to confirm if the patient presented a risk of harm to themselves or to other patients and staff.

One consultant had documented a patient’s wish that they receive life-sustaining treatment at the expense of comfort and quality of life. The doctor had noted they had followed hospital guidance, which we were unable to confirm existed. In addition, the doctor had noted the patient had mental capacity, which other notes indicated was untrue. Despite the patient’s wishes, the consultant had authorised a do not attempt resuscitation (DNAR) order. We escalated this at the time of our inspection to the nurse and consultant in charge on the ward, who said they would review the patient immediately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. This was clearly documented in all records we looked at, including where patients had reduced capacity to consent. Staff demonstrated a clear understanding that capacity assessments and consent processes were decision and procedure-specific.

When patients could not give consent, staff made decisions in their best interest, took into account patients’ wishes, culture and traditions. In all but one of the documents we checked, staff had carried out daily reassessments for patients who lacked capacity. In each case they documented justification for restrictions on the patient’s independence. However, in one instance we found staff had not reviewed a patient’s capacity for seven days. We discussed this with staff who addressed the situation.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in patients’ records. All documents we looked at were completed consistently and included additional information when patients had complex needs, such as when they had a chemical sedation care plan in place.

All nursing staff were required to complete training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The MCA training delivered covers all levels required and DoLS training is included in the same session so is not reported separately.

Compliance for the MCA/DoLS training course as of February 2019 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
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<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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In medicine the target was not met for the MCA/DoLS training module for which qualified nursing staff were eligible, although the completion rate was above 88%.

Compliance for the MCA/DoLS training course as of February 2019 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>95</td>
</tr>
</tbody>
</table>

In medicine the target was not met for the MCA/DoLS training module for which medical staff were eligible, although the completion rate was above 85%.

Compliance for the MCA/DoLS training course as of February 2019 at Pilgrim Hospital for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>147</td>
</tr>
</tbody>
</table>

In medicine the target was not met for the MCA/DoLS training module for which qualified nursing staff were eligible.

Compliance for the MCA/DoLS training course as of February 2019 at Pilgrim Hospital for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>24</td>
</tr>
</tbody>
</table>

In medicine the target was not met for the MCA/DoLS training module for which medical staff were eligible.

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

We found consistent standards of DoLS documentation on wards and staff demonstrated a good understanding of their responsibilities. However, the hospital did not routinely receive authorisations back from the local authority, which meant staff were restricted in their ability to fully comply with the requirements. On ward 8B, staff had applied for a DoLS authorisation for one patient in April 2019 and not received a response or update since then.

Staff had not always documented whether a discussion had taken place with relatives in relation to a DoLS application. However, we saw proactive use of independent mental health advocates (IMCAs) to support patients and staff during best interest processes.

Staff used a DoLS scoping tool to maintain on-going assessment of patients with fluctuating capacity, such as when this was likely to improve with medical treatment. This ensured patients were protected from harm without the need to restrict their liberties immediately.
The nursing team on the stroke ward had significantly increased their DoLS compliance training following a serious incident that involved a patient living with dementia. They carried out ad-hoc assessments on a peer-review basis and discussed DoLS applications during board rounds and handover. Staff described highly problematic relationships with the local authority and said they did not receive support for complex cases and most communications were ignored. The increase in training and peer-review was therefore intended to help the team be self-sufficient in relation to DoLS.

**Is the service caring?**

**Compassionate care**

*Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.* This was the case during most of our inspection although there were some notable examples of poor care.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness during the majority of our observations. However, on the acute medical short stay unit (AMSS), one patient and two relatives described poor standards. For example, one relative said they had been upset when they overheard staff talking about a patient and referred to them as a “nuisance.” One patient told us they had wanted a cup of tea when the tea trolley had passed but the member of staff had rushed past them without giving them time to ask. Our inspector asked a member of the housekeeping team for a cup of tea for the patient and was told they had missed it because they had not asked quickly enough when the tea trolley had passed. Also on AMSS a relative said they observed staff speak to two elderly patients abruptly when they tried to change their beds. On ward 8A we observed a member of staff refer to a patient unkindly and using unprofessional language.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The Friends and Family Test response rate for medicine at the trust was 27%, which was better than the England average of 24% from March 2018 to February 2019.

Please note that the response rates for some wards/units were low, for example wards 7B and 8A had response rates of 17%. Care should be taken when interpreting the recommendation rates for these wards and units as the small sample size will impact on the ability to generalise the results. In addition, Ward 6B had a response rate of over 100% suggesting issues with the data quality.

A breakdown of FFT performance by ward for medical wards at trust level over the same time period is shown below. All the wards and departments had annual recommendation rates of 80% and above with the exceptions of Wards 8A and 7B which had an annual recommendation rate of 73% and 79%, respectively.
### Table 1: FFT Performance by Ward

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp1,2</th>
<th>Resp. Rate</th>
<th>Percentage recommended2</th>
<th>Annual perf1</th>
</tr>
</thead>
<tbody>
<tr>
<td>6B</td>
<td>329</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 6</td>
<td>285</td>
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<td>100%</td>
</tr>
<tr>
<td>Ward 1</td>
<td>277</td>
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<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Burton</td>
<td>267</td>
<td>39%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>6A</td>
<td>261</td>
<td>64%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>CSSU</td>
<td>251</td>
<td>26%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Johnson</td>
<td>229</td>
<td>26%</td>
<td>83%</td>
<td>92%</td>
</tr>
<tr>
<td>Carlton Coleby</td>
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<td>21%</td>
<td>93%</td>
<td>75%</td>
</tr>
<tr>
<td>Waddington</td>
<td>198</td>
<td>19%</td>
<td>86%</td>
<td>94%</td>
</tr>
<tr>
<td>Frailty Assessment Unit</td>
<td>166</td>
<td>27%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>7A</td>
<td>155</td>
<td>20%</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>Dixon</td>
<td>131</td>
<td>17%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Lancaster</td>
<td>131</td>
<td>17%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>7B</td>
<td>130</td>
<td>17%</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>6A</td>
<td>127</td>
<td>17%</td>
<td>60%</td>
<td>73%</td>
</tr>
</tbody>
</table>

Key: Highest score to lowest score

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

The Friends and Family Test response rate for medicine at Pilgrim Hospital was 31% which was better than the England average of 24% from March 2018 to February 2019.

Please note that the response rates for some wards/units were low, for example wards 7B and 8A had response rates of 17%. Care should be taken when interpreting the recommendation rates for these wards and units as the small sample size will impact on the ability to generalise the results. In addition, Ward 6B had a response rate of over 100% suggesting issues with the data quality.

A breakdown of FFT performance by ward for medical wards at Pilgrim Hospital over the same period is shown below. Ward 8A had the lowest overall annual recommendation rate, at 73%, followed by Ward 7B with 79%.

### Table 2: FFT Performance by Ward

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp1,2</th>
<th>Resp. Rate</th>
<th>Percentage recommended2</th>
<th>Annual perf1</th>
</tr>
</thead>
<tbody>
<tr>
<td>6B</td>
<td>329</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>261</td>
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<td>100%</td>
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</tr>
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<td>7A</td>
<td>155</td>
<td>20%</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>7B</td>
<td>130</td>
<td>17%</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>8A</td>
<td>127</td>
<td>17%</td>
<td>60%</td>
<td>73%</td>
</tr>
</tbody>
</table>

Key: Highest score to lowest score

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Ward teams displayed feedback they received from patients, including thank you cards and letters. Staff spoke proudly of these, which were evidence of the standard of care they delivered. For example, comments received on ward 7B included, “You do a magnificent job”, and, “Very friendly
and welcoming.” The team on ward 6B had displayed over 30 thank you cards recently received. Themes of positive feedback included about, “kind staff”, good food and, “comfy beds.”

Staff on ward 6B had developed a bespoke dignity campaign for patients. This included quotes from previous patients and guidelines for staff on how to deliver care that ensured privacy, dignity and respect. For example, patients had said it was beneficial for them to wear their own clothes and to feel in control of how they looked.

Staff in a number of areas told us they felt the level of dignity they could provide for patients was sometimes affected by severe short-staffing. For example, one member of staff on ward 6A said they had let a patient wet their bed because there were not enough staff to escort them to the toilet. We did not see this in practice during our inspection and we discussed it with senior staff in the service. The team was unaware of this and it had not been reported as a formal incident.

The endoscopy team kept a feedback book in the reception area and the team reviewed comments periodically. We looked at a sample of feedback and found most comments to be very positive. Patients noted the professionalism of the team and said this helped to alleviate their anxiety about uncomfortable procedures.

We observed ward clerks and receptions provide a friendly, welcoming and polite service to patients and visitors. In the endoscopy unit we saw the receptionist was attentive to patient’s needs and provided information on how their appointment would run.

In the 2018 patient led assessment of the care environment (PLACE), the hospital scored 76% for privacy, dignity and wellbeing. This was worse than the national average of 84%.

**Emotional support**

*Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.*

Staff gave patients and those close to them help, emotional support and advice when they needed it. This included through their daily contact in addition to structured programmes such as a carer’s charter and the implementation of the national John’s Campaign. Both programmes promoted emotional support through a caring, personalised approach to communication and the delivery of treatment.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

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

*Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.*

Staff made sure patients and those close to them understood their care and treatment. We observed numerous examples of this during our inspection and saw it was common practice for staff to patiently explain to patients why they needed certain care or treatment. For example, on ward 7B one patient was anxious and distressed about a blood test, which they had previously found unpleasant. The nurse was patient, kind and explained simply why it was important to have another blood test. They talked to the patient throughout to distract them and promised to be as fast they could.
Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care. Staff used adapted communication tools to help patients understand their care and to make decisions. For example, we observed one nurse use a large-print written notice to ask a patient if they were happy to have their blood pressure checked.

Wards 6A and 6B, which provided care to older people, used a carer’s charter to provide support to people who cared for patients at home or in the community. This included providing free car parking and support to access refreshments on site.

We observed a patient being admitted to ward 6A during our weekend unannounced inspection and saw staff were warmly welcoming. They addressed the patient by name, explained who they were and provided friendly and compassionate care from the outset. The patient’s nurse explained why they had been transferred and told them what they expected to happen next. They also spoke with the patient’s relatives and explained the transfer.

During board rounds, discharge coordinators and social care professionals worked with the multidisciplinary team to plan the involvement of patients’ relatives in their package of care ahead of planned discharge. We observed this process in practice and saw it worked in the best interest of the patient. For example, nurses, doctors and allied health professionals (AHPs) highlighted to community colleagues when they felt a patient would struggle at home so that the team could engage with relatives to plan support. We saw occupational therapists and physiotherapists took lead roles in establishing a package of care for patients and placed significant focus on each patient’s abilities and understanding of their own needs. For example, where the team believed patients could mobilise safely but lacked confidence to do so, they worked with them to address this to secure a safe discharge.

Each ward had established visiting times for relatives and friends. However, staff worked flexibly within these times to facilitate the needs of each patient. During our inspection we saw staff provided blankets and comfortable chairs for relatives to sleep in when a patient was critically unwell.

AHPs involved relatives in discharge and rehabilitation plans to help them get involved in the patient’s exercise plans. For example, physiotherapists invited relatives to take part in exercise sessions and showed them how to safely support their family member. Staff we spoke with described relatives as a “key part” of every patient’s recovery and ongoing health.

Staff used a trust-wide ‘RESPECT’ tool that ensured they documented and considered patient’s wishes during care planning. This was a template that enabled any staff carrying out an assessment to consider the patient’s holistic needs.

One patient on the oncology ward travelled considerable distance for treatment because they found the standards of care to be better than their local hospital. They said, “The staff here explain everything in a way which makes it completely clear.”
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Allied health professionals (AHPs) created guidelines for clinical referrals and training for nursing teams. The AHP team worked responsively to meet the needs of patients and colleagues in medical specialties, for example by moving their routine timeslots to accommodate ward activity.

The AHP team had carried out research to identify where their most positive impact could be in light of large-scale recruitment challenges. The senior team had also carried out a skill mix review and introduced junior posts to physiotherapy and occupational therapy (OT) to better plan the service for patients.

The trust had reduced the availability of ringfenced beds for non-invasive ventilation (NIV) and for thrombolysis. NIV beds had reduced from five to one and the site team regularly admitted patients to the single thrombolysis room on the stroke ward who did not need this treatment. This reduced the ability of both specialties to meet urgent or acute needs and staff raised this as a significant concern with us.

The dietetics team provided care to both inpatients and outpatients as the county had no community service provision. The trust had trialled a seven-day service, which staff said had been successful but was subsequently discontinued by the trust without notice.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We saw evidence of this during our observations of practice and from our discussions with staff.

Facilities and premises were appropriate for the services being delivered. Each ward and clinical area had accessible areas for patients and visitors who used wheelchairs and adapted premises for bariatric care.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. This was provided through a combination of internal provision by senior nurses and community-based mental health organisations.

The service had systems to help care for patients in need of additional support or specialist intervention. However, these systems were not always functioning. For example, staff could request enhanced care for a patient, which involved a trained member of staff working with the patient on a one-to-one basis. During our inspection two patients who needed additional support did not receive this because of a lack of staff availability.

In the chemotherapy suite, staff monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted.

The acute medical short stay (AMSS) ward did not carry out cardiac monitoring, which meant patients were transferred to the acute cardiac unit (ACU) or to ward 7B. However, the nurse in charge told us work was underway to rectify this. The AMSS was designed to care for patients for
a maximum of 72 hours. However, this was extended if patients deteriorated or needed an extended course of antibiotics.

A physiotherapist had introduced a handover book on wards 6A and 6B to ensure continuity and consistency of handover documentation. Prior to this staff had no tools to track daily patient updates and the handover book represented a number of improvement strategies the physiotherapist planned to introduce.

The chemotherapy suite team had reconfigured the unit into two dedicated areas; one for chemotherapy and one for haematology. This enabled the dedicated team to deliver more focused care and to plan slots more efficiently.

Doctors in oncology and haematology said they had an excellent working relationship with colleagues in palliative care and end of life care, which resulted in good access to hospice care for patients.

The endoscopy team provided an unsocial hours provision for inpatients with urgent needs, such as for upper gastrointestinal bleeds and obstructions.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff planned for patients living with mental health problems, learning disabilities and dementia to receive the necessary care to meet all their needs. This included through the enhanced care programme, which provided one-to-one support for patients with more complex needs, including for their social care. The enhanced care programme required staff to provide personalised interaction with patients to reduce the risk of isolation and a targeted approach to involving the patient’s relatives in their care. However, we observed the hospital was not always able to provide planned enhanced care because of staff shortages. For example, one patient required one-to-one care during a transfer to another hospital for diagnostic testing. This was not available and so the process was delayed. During our weekend inspection we found two patients who needed enhanced care had not received this because of short staffing. This added additional pressure to the existing ward team and reduced their ability to meet the patient’s holistic needs.

Wards were designed to meet the needs of patients living with dementia. For example, the team on ward 6B had refurbished a day room to a high standard. They had worked with patients and relatives to identify resources they would find useful and furnished it with mechanical chairs, which OTs used to help build patients’ independence and confidence. The team had also provided sensory lamps, reminiscence materials, a foosball table, a collection of books, and a piano. The room included an OT therapy kitchen for rehabilitation as well as games and toys and was designed with multiple needs in mind, including cognitive impairment. The dementia practitioner on ward 6A was leading a refurbishment project for a similar day room, which was planned for completion in July 2019. Wards 6A and 6B were equipped with pictorial signs designed to help patients living with dementia orientate themselves. They included large-print, easy-read dates and days of the week as well as visual symbols to depict the weather. The signs were prominently located in each bed bay although staff did not keep them up to date with dates or the weather, which meant they would be ineffective.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Dedicated dementia practitioners and a learning disability nurse worked across the hospital and provided on-demand care and support to patients.
In the 2018 patient led assessment of the care environment (PLACE), the hospital scored 72% for the care of patients living with dementia and 83% for the care of patients living with a disability. This was lower than the national average for both measures. Nationally, hospitals scored an average of 80% for dementia care and 84% for disability care.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Speech and language therapists (SaLTs) provided care to patients in the hospital and were employed by another organisation through a service level agreement (SLA). There were significant staffing issues in the SaLT team and the organisation had launched a county-wide recruitment plan in response.

Physiotherapists and OTs provided inpatient gym rehabilitation sessions for cardiac patients, including in a hydrotherapy pool. However, the ability of the team to deliver full rehabilitation was restricted by significant levels of short staffing. This meant the team was unable to use dedicated therapy facilities on site to their full potential and had to adapt exercises to the ward environment to save time. For example, therapists on ward 6A said they were unable to use the therapies rehabilitation kitchen because it took too much time to transfer patients there and instead they adapted exercises patients could do in their bed bay or in a stairwell.

Dedicated dementia practitioners worked on wards 6A and 6B and provided patients with one-to-one cognitive and social support. A hospital dementia family support worker provided on-demand services to patients and their relatives. This individual worked for a different organisation and advertised their services on the wards. Dementia practitioners had substantially increased the resources and opportunities for patients to socialise and engage in meaningful activities. For example, practitioners had introduced dementia cafes for patients and their relatives. One practitioner had researched the benefits of music therapy and had introduced a range of initiatives in ward 6A to help patients relax and promote physical recovery. For example, they researched the music that was popular at the time of their patients’ childhood and played this for them through online streaming music services. During our weekend unannounced inspection, we saw this therapy had a significant, positive impact on patients. Patients recognised the music and they sang along to it. Through this process the practitioner found one patient had been a piano player and they used software on the RITA system to enable the patient to play along to the music. They recognised that church music and hymns had been popular for many elderly patients and they had prepared a playlist for them. RITA is a mobile interactive computer system designed to provide stimulation for patients living with dementia. The practitioner asked patient’s families about where they grew up and had gone to school and researched these to find photographs they could use for reminiscence therapy.

Staff worked together to identify patients’ emerging needs. For example, staff on ward 6A had identified one patient’s mental state had deteriorated since being moved to a side room due to an infection. The multidisciplinary team worked together to provide them with more contact and move them back into a shared bay as soon as possible. Physiotherapists worked with nursing colleagues to introduce night-time diaries for patients whose relatives were concerned about their agitation overnight.
Discharge coordinators and AHPs worked with community partners to implement therapy plans in accordance with a national gold standard framework. This reduced the risk of readmission and provided patients with a planned rehabilitation pathway.

An alcohol liaison nurse was available in the hospital and provided liaison with community drug addiction agencies to support patients admitted with needs relating to substance misuse and dependency.

We found staff used communication tools to support discussions with patients and to help meet their needs. However, this was not the case for every patient. For example, on ward 8B we found a patient had lost the ability to speak during their inpatient stay. However, there was no evidence staff had taken action to support communication.

A dedicated team of volunteers worked across clinical areas to provide additional support to patients. Ward managers identified how volunteers could be of benefit to patients and made an application to the volunteer services manager. This enabled the manager to deploy volunteers based on their experiences, preferences and training. This team prioritised befriending patients to reduce the risks of social isolation and to provide pastoral care. The team provided around 4000 hours of support per month to patients across the trust, with approximately 50% of medical areas at this hospital covered. Volunteers were attached to a range of teams, including porters for meet and greet duties and to the chaplaincy. Some volunteers were able to provide language support to patients in non-clinical circumstances.

The chemotherapy team provided a series of colourful books for children to help them understand cancer and its treatment. These were advertised in the department and were designed to help explain clinical treatment to young people in an accessible, age-appropriate format.

The estates team offered a 30-minute response time to wards for urgent needs. Patients and visitors used lifts to access most medical areas and an on-call system provided an immediate response to breakdowns. The estates team had improved access to lifts with call buttons inside designed to be user-friendly, such as with braille and large numbers for people with sight impairments.

**Access and flow**

**People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. For example, staff in the chemotherapy suite and the endoscopy unit cared for patients on an outpatient basis and delivered this within timeframes according to each patient’s care plan.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. This applied to services delivered on an outpatient basis, such as chemotherapy and endoscopy. Both services provided pre-arranged, elective care and staggered appointment times to reduce the risk of delays or extended waits.

Managers and staff worked to make sure patients did not stay longer than they needed to. We saw evidence of this during board rounds, which multidisciplinary staff used to plan patient care and discharge. Staff clearly recognised the risks to patients of extended, unnecessary inpatient stays and planned care to reduce this.
From January 2018 to December 2018 the average length of stay for medical elective patients at the trust was 5.5 days, which was lower than the England average of 6.0 days.

Of the top three specialties by number of admissions, average lengths of stay for elective patients in clinical oncology, gastroenterology and clinical haematology were lower than the England averages.

**Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>5.5</td>
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</tr>
<tr>
<td>Clinical oncology</td>
<td>2.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>2.8</td>
<td>4.5</td>
</tr>
<tr>
<td>Clinical haematology</td>
<td>8.8</td>
<td>10.7</td>
</tr>
</tbody>
</table>

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

For medical non-elective patients, the average length of stay was 6.4 days, which was similar to the England average of 6.2 days.

Of the top three specialties by number of admissions, average length of stay for non-elective patients in:
- General medicine was higher than the England average.
- Cardiology was similar to the England average.
- Clinical oncology was lower than the England average.

**Non-Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
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</tr>
<tr>
<td>General medicine</td>
<td>6.4</td>
<td>5.7</td>
</tr>
<tr>
<td>Cardiology</td>
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</tr>
<tr>
<td>Clinical oncology</td>
<td>3.4</td>
<td>5.3</td>
</tr>
</tbody>
</table>

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

From January 2018 to December 2018 the average length of stay for medical elective patients at Pilgrim Hospital was 4.2 days, which was lower than England average of 6.0 days.

For the top three specialties by number of admissions, average length of stay for elective patients in:
- Gastroenterology was lower than the England average.
- Respiratory physiology was the same as the England average.
- Medical oncology was higher than the England average.
For medical non-elective patients, the average length of stay was 6.4 days, which was similar to England average of 6.2 days.

Of the top three specialties by number of admission, average length of stay for non-elective admissions in:
- General medicine and cardiology were higher than the England averages.
- Medical oncology was lower than the England average.

(Source: Hospital Episode Statistics)

From March 2018 to February 2019 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was consistently lower than the England average.

In the most recent month, February 2019, the trust performance was 76.8% compared to the England average of 87.2%.

(Source: NHS England)
From March 2018 to February 2019, two specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>90.3%</td>
<td>81.6%</td>
</tr>
</tbody>
</table>

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>Gastroenterology</td>
<td>65.4%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>58.7%</td>
<td>81.3%</td>
</tr>
<tr>
<td>General medicine</td>
<td>50.0%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Neurology</td>
<td>50.0%</td>
<td>90.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The trust reported that they do not collect data on ward moves for non-clinical reasons.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

From March 2018 to February 2019, there were 5,731 patient moving wards at night within medicine trust-wide.

From March 2018 to February 2019, there were 1,113 patient moving wards at night within medicine at Pilgrim Hospital. The ward with the highest number of moves was Ward 8A with 209 (18.8%).

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Managers and staff worked to make sure that they started discharge planning as early as possible. Clinical staff established a planned discharge date for each patient when they were admitted and reviewed this daily during their care. This helped to focus and coordinate care across the multidisciplinary team and we observed good standards of practice to maintain safe discharge plans.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. They coordinated multidisciplinary care and ensured relevant specialists reviewed patients prior to discharge to ensure was safe and appropriate.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Staff identified trends in discharge delays and tried to pre-empt these to reduce impact. For example, reviews from some specialties were often delayed because of a lack of capacity in the teams, which caused discharge delays.

Staff supported patients when they were referred or transferred between services. They coordinated care with community colleagues and teams to ensure patients received ongoing care and treatment after discharge.

Managers monitored patient transfers and followed national standards. Senior staff said they only transferred patients when it was necessary although ward-based staff said they were not routinely included in such decisions. This meant clinical staff responsible for patient care did not maintain oversight of patient’s care and needs during transfers.
Managers did not always make sure they had arrangements for medical staff to review any medical patients on non-medical wards. We spoke with staff on surgical wards who described challenges in obtaining medical reviews and we saw evidence of delays in consultant review.

A multidisciplinary team coordinated discharges each day, with a discharge lead supporting the process. This included twice-daily ‘red to green’ meetings, which referred to meeting targets for each patient’s discharge. Discharge coordinators attended bed meetings at site level and individual ward board meetings, which staff used to review the plan for each patient. OTs and physiotherapists were a part of this process and provided specialist input into each of their patients. We saw adult social care professionals also attended meetings to provide planning support for patients ahead of their discharge home or into the community.

Dieticians managed their own stock of supplies needed for patient discharges and provided a rapid one-hour response time to urgent referrals from ward staff. The team coordinated patients’ package of care planning to ensure they received appropriate future appointments for dietetic review on an outpatient basis.

AHPs worked with community reablement services to provide short-term homecare for patients, often at short notice, whilst they were awaiting a long-term care plan. This helped to reduce discharge delays and helped patients to return to their baseline condition and ability more quickly.

The AHP team offered a range of follow-up and virtual clinics, including for fractures, enhanced recovery from radiotherapy and allergy treatment.

**Learning from complaints and concerns**

*It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.*

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

From March 2018 to February 2019 the trust received 128 complaints about medicine (17.6% of total complaints received by the trust). The trust took an average of 58.7 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be dealt with within 35 working days, or 50 working days for more complex complaints.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>30</td>
<td>23.4%</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>26</td>
<td>20.3%</td>
</tr>
<tr>
<td>Patient care</td>
<td>22</td>
<td>17.2%</td>
</tr>
<tr>
<td>Admission &amp; discharges (excluding delayed discharge due to absence of a care package)</td>
<td>19</td>
<td>14.8%</td>
</tr>
<tr>
<td>Values and behaviour</td>
<td>7</td>
<td>5.5%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>7</td>
<td>5.5%</td>
</tr>
<tr>
<td>Privacy dignity and wellbeing</td>
<td>6</td>
<td>4.7%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>5</td>
<td>3.9%</td>
</tr>
<tr>
<td>Safeguarding - patient care</td>
<td>2</td>
<td>1.6%</td>
</tr>
<tr>
<td>Safeguarding - privacy dignity</td>
<td>1</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
End of life care  1  0.8%
Safeguarding - values behaviours  1  0.8%
Access to treatment or drugs  1  0.8%
Total  128  100.0%

Breakdown by site can be seen below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital, Boston</td>
<td>61</td>
<td>47.7%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>57</td>
<td>44.5%</td>
</tr>
<tr>
<td>Grantham &amp; District Hospital</td>
<td>10</td>
<td>7.8%</td>
</tr>
<tr>
<td>Total</td>
<td>128</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

From March 2018 to February 2019, Pilgrim Hospital received 61 complaints in relation to medicine. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>13</td>
<td>21.3%</td>
</tr>
<tr>
<td>Admission &amp; discharges (excluding delayed discharge</td>
<td>13</td>
<td>21.3%</td>
</tr>
<tr>
<td>due to absence of a care package)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient care</td>
<td>9</td>
<td>14.8%</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>6</td>
<td>9.8%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>5</td>
<td>8.2%</td>
</tr>
<tr>
<td>Privacy dignity and wellbeing</td>
<td>4</td>
<td>6.6%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>3</td>
<td>4.9%</td>
</tr>
<tr>
<td>Values and behaviour</td>
<td>3</td>
<td>4.9%</td>
</tr>
<tr>
<td>Safeguarding - patient care</td>
<td>2</td>
<td>3.3%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td>Safeguarding - values behaviours</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td>Total</td>
<td>61</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

From March 2018 to February 2019, there were 9,032 compliments about medical care at the trust. A breakdown of compliments by site is below

<table>
<thead>
<tr>
<th>Site name</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of compliments</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>4,356</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>2,191</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>2,054</td>
</tr>
<tr>
<td>County Hospital Louth</td>
<td>230</td>
</tr>
<tr>
<td>Pan trust</td>
<td>201</td>
</tr>
<tr>
<td>Total</td>
<td>9,032</td>
</tr>
</tbody>
</table>

The trust noted that, alongside the compliments received by wards and services, there were an additional 746 comments recorded trust-wide. These were comments from patients, families and staff directly to the services and staff with whom they came in contact.

A theme from the compliments received trust-wide was good communication. From March 2018 to February 2019, there were 2,054 compliments about medicine at Pilgrim Hospital. A breakdown of compliments by department is below:
### Site name | March 2018 to February 2019
---|---
**Number of compliments** | **Percentage of total**
Ward 6B | 746 | 36.3%
Endoscopy unit | 437 | 21.3%
Ward 8B (stroke unit) | 431 | 21.0%
Ward 6A | 138 | 6.7%
Acute cardiac unit | 131 | 6.4%
Ward 8A | 78 | 3.8%
Acute medical unit | 50 | 2.4%
Ward 7B | 43 | 2.1%
**Total** | **2,054** | **100.0%**

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

A dedicated complaints coordinator maintained oversight of complaints in medical services. At the time of our inspection, there were 16 complaints that had exceeded the trust’s maximum 35 days for resolution. All complaints required director-level approval before a final resolution. Six of the 16 overdue complaints were awaiting director sign-off. The complaints coordinator said the backlog was slowly being reduced although this was affected by the workload of ward clerks and challenges in tracking patient records.

Each complaint had a named lead who kept the complainant up to date as the investigation progressed using their preferred method of communication. The complaints coordinator worked with the patient advice and liaison service (PALS) to agree the outcomes of each case. Senior clinicians intervened where patients or relatives approached PALS and an immediate medical intervention was needed.

We found evidence staff took action to address complaints and implement improvements. For example, the relative of a patient raised concerns about the standard of end of life care on ward 6A. In response the team improved provisions for overnight stays, including facilities to make food and drinks. The ward team invited the complainant back to the ward to look around and provide feedback. This was a successful process that resulted in the complainant becoming a hospital volunteer.

Discharge-related issues such as delays or lack of to take-away medicines were involved around 25% of complaints. Permanent staff on each ward had a clear understanding of their complaint themes and rates. For example, complaints on ward 7B and the chemotherapy suite were very rare whereas staff on AMSS regularly received complaints.

Complaints formed part of the ward quality assurance process and some teams had developed strategies to share learning. For example, the team on ward 7B had implemented a secure, restricted-access social media communication group to discuss learning from complaints.
Is the service well-led?

Leadership

Leaders at a local level had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles, although this was restricted by a lack of resources and senior trust input.

The trust had reconfigured senior teams through a trust operational model (TOM) project. The new leadership structure included a clinical director or clinical advisor, a divisional nurse or lead clinician and a managing director for each service. In medicine, both the clinical director and managing director were interim posts. The new team demonstrated an understanding of the challenges and risks in the division and had early-stage plans to address the key factors, such as staffing levels. The team was well-versed in service redesign and planned to utilise more clinical multidisciplinary working strategies and to utilise different types of staff, such as advanced nurse practitioners, to deliver the service. Staff said it was too early to tell if this was a long-term positive change but said it had resulted in improved sharing of learning and good practice so far.

A team of five matrons worked within the TOM structure that meant they worked in their service specialty across the trust’s hospitals. This meant matrons typically worked between one day and three days per week at this hospital. All of the staff we spoke with described good relationships with their respective matron and said the amount of time they spent on their ward felt appropriate. Matrons were arranged into the following services: cardiology and stroke; diabetes and renal; gastroenterology and respiratory; healthcare for older people (HCOP); and oncology and chemotherapy. Consultant clinical lead posts were attached similarly to pairs of services, but most posts were vacant. Only HCOP and diabetes and renal medicine had clinical leads in post.

The chief nurse held weekly ward manager meetings as part of a service and leadership reconfiguration, which staff spoke positively about. However, they said this was the only opportunity to meet senior nurses and there was limited senior input during usual operations.

There were significant gaps or contradictions in staff understanding of leadership in some specialties. For example, respiratory medicine (ward 7B) had a matron and a senior nurse, both of whom were away from work on a long-term basis. Staff said another matron, “popped in occasionally”, to check on them but could not confirm who this was or how they could contact them for support. However, other staff said trust had established structured leadership support in the absence of the permanent team.

An operational matron of the day coordinated staffing operations across medicine and responded to shortages and specific challenges.

The emergency department matron was responsible for the acute medical short stay (AMSS) unit and the integrated assessment centre (IAC) although both units were placed within the medical division. This meant the senior team worked between divisions.

The matron post for endoscopy was vacant, which staff said affected their ability to escalate operational issues. During our unannounced weekend inspection, staff were initially unsure who was in charge of the site. This meant we were not assured every department had an immediate point of escalation for emergencies or service problems.

A service manager and lead nurse for cancer led the chemotherapy and oncology service, which was in a separate division from medical specialties.
Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress but knowledge amongst staff was highly variable.

The trust had implemented a vision, to be achieved by 2021, that incorporated a staff charter and personal responsibility framework for each member of staff. Of the 19 members of staff we asked about this, three individuals demonstrated an understanding of it and what it meant for patients and for their practice. Other staff were highly critical and spoke of substantial gaps in communication with the trust.

Some ward teams had developed their own vision or philosophy of care. For example, the team on ward 7B had developed a vision based on the core principles of compassion, positive attitude, respect and equality. Staff on wards 6A and 6B had established a ward philosophy and staff charter that reflected the needs of patients and the commitment of staff. We asked staff about this work and they said it helped to guide the service they provided during prolonged periods of short staffing by providing a standard for temporary and new staff to work towards.

The volunteer services manager had a vision of one volunteer per day on every ward and in every clinical area. They were working towards this with plans to increase recruitment and to work with ward managers to increase their understanding of the role of volunteers.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work but provided only limited opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There had been a significant reconfiguration in the hospital in the 18 months leading to our inspection, which staff described as challenging and ultimately positive. They said the new structure meant there was better visibility of senior staff and they felt more valued.

Staff in some services described morale as low but improving. For example, staff in the stroke service said a new matron had brought an approachable, friendly element to a leadership structure that had previously been challenging. They had scheduled drop-in sessions for staff that facilitated a more positive working environment.

Staff had a good knowledge of the trust's whistleblowing process and could articulate how they would report concerns about conduct or behaviour.

The head of therapies told us all AHPs had contributed to the development of the service's values, ambitions, programmes and staff charter work. This reflected the trust's overarching 2021 strategic plan. However, knowledge amongst AHPs was highly variable and three staff said they were unaware of this work and had not been involved.

Although we observed numerous, excellent examples of multidisciplinary care, these working relationships were not always reflected amongst ward teams. We observed examples of disrespect from a consultant towards nursing staff on some wards, including a dismissive attitude when a senior nurse asked a consultant multiple times to document conversations they had conducted about a patient's care. As the consultant hadn't documented the discussions for several
days, the patient’s relatives were becoming increasingly frustrated with the lack of a care plan. The consultant was unconcerned about this.

We spoke with some staff who said they were leaving the hospital because of continuous stress and excessive workloads. Staff were particularly concerned about the turnover of advanced nurse practitioners (ANPs). One ANP said they had asked to speak with senior trust staff about avoiding their departure by improving working conditions but said they had not received a reply to any of their communications. Staff said they were not asked why they were leaving and said there was a lack of interest in reducing turnover by identifying why some staff left.

A new matron was in post for haematology and oncology and had set up a programme of monthly cross-site meetings for senior nurses.

Junior doctors spoke highly of a rota coordinator who worked to provide solutions to service provision challenges whilst respecting personal circumstances. The coordinator provided a pastoral function that included defusing problems and conflicts by phone, on-demand for junior doctors.

Although staff described good working relationships with locum consultants, there were gaps in communication. Staff said consultants often gave no notice to patients that they would need to stay overnight in the ward. A senior nurse said, “We often have to grovel and apologise. It’s demeaning.”

**Governance**

Leaders operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance processes were variable between wards and clinical services. In some areas, governance was clearly embedded in day-to-day operations and in others, staff were unsure about local procedures.

The trust had recently restructured divisions and leadership teams under a trust operational model (TOM) programme. As a result, most medical services were organised into the medicine division, with three sub-divisions: urgent and emergency care; cardiovascular and specialty medicine. The cardiovascular sub-division included cardiology, stroke, endocrinology, diabetes and renal. For inpatient care, specialty medicine included gastroenterology, respiratory and health care of the older person (HCOP). Haematology, oncology and chemotherapy were part of the cancer sub-division within the clinical support division. Endoscopy, respiratory and all therapies modalities were part of the diagnostics sub-division of clinical support.

Dieticians and speech and language therapists attended a bi-monthly, trust-wide nutrition and hydration meeting. The team used this process to ensure the service could meet demand and to ensure it adhered to the latest national and international guidance. For example, the team used this governance process as part of a working group to improve the options for textured food in line with international descriptor changes in 2018.

Allied health professionals (AHPs) attended team and specialty meetings variably. For example, some physiotherapists said their regular team meeting was always at a time they were not on shift due to their working hours. This meant they did not regularly have the chance to meet colleagues or managers.

It was not evident divisional leadership teams acted on the risks and challenges in clinical specialties. For example, a backlog of 210 incident reports had accumulated in respiratory medicine over a four-year period. Staff told us this occurred because of frequent leadership...
changes. There was no evidence senior divisional or trust staff had addressed the causes of this backlog or assessed the impact and it was not listed on the risk register. The ward manager had recently been seconded into the post and had escalated the issue to be added to the risk register. The team had introduced more consistent governance processes as a result of the situation. This included monthly meetings attended by the matron, senior nurses, trust governance team and consultants. We were unable to establish why the improved governance structure had not resulted in a reduction in the incident report backlog.

Inpatient oncology and chemotherapy services were part of the clinical support services division. This had recently changed as part of a restructure and senior staff said it helped the service to focus on very unwell patients and avoid emergency department admissions.

Consultant-led morbidity and mortality (M&M) meetings took place variably across clinical specialties. In the acute medical short stay (AMSS) unit and the integrated assessment centre (IAC), these took place monthly and clinical staff reviewed a sample of three cases. Lessons learned were discussed locally and shared with a trust RAG (red, amber, green) committee.

The stroke team held a governance meeting periodically and the most recent three meetings had taken place between January 2019 and May 2019. We looked at the minutes for each meeting and found the team had reviewed patient safety, areas of low performance, service risks and workforce needs. They also used the meetings to review audit performance and compliance with areas such as the duty of candour.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues but actions to reduce their impact were not always taken. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Matrons led a safety and quality dashboard (SQD) programme that monitored governance on wards on a continuous basis. This was a tool to measure the standard of care and practice on each ward or unit and enabled staff to identify areas for improvement and to track. The SQD dashboard included 14 categories for staff to monitor, such as nasogastric feeding, tissue viability, fluid management and catheter care. We reviewed the 12-month trackers for each clinical area we inspected. Data was consistently submitted and although there was limited evidence they resulted in embedded, sustained improvements, ward staff had created action plans and new improvement initiatives to address areas of concern.

The senior team on ward 6A had established an SQD action plan to address areas for improvement identified during monthly reviews and audits. We looked at the most recent results, which related to April 2019 and May 2019. The action plan process had resulted in an improvement of SQD actions completed within 24 hours from 54% to 84%. However, other measures that needed improvement had not been met. For example, in both months, compliance with documentation standards for target oxygen saturation levels and oxygen therapy was 0%. In addition, compliance with the completion of medicine fridge temperature documentation had decreased from 100% in April 2019 to 0% in May 2019 and completion of mandatory trust documentation by consultations remained low, at 33%.

Divisional and service teams used risk registers to identify, track and monitor risks. However, it was not event this was always effective at reducing risk or improving performance. For example, the estates team was responsible for maintaining increasingly ageing and demanding facilities, but the trust had restricted their ability to recruit in response. Staffing was a consistent theme in every service risk register.
Staff said the future of the stroke service was uncertain. The trust had redeployed three senior nurses to support the service during staff shortages, but staff said a lack of communication about this meant they had not been included in ongoing plans. It was common practice for stroke nurses to be redeployed to the emergency department to help staff deliver thrombolysis treatment. One member of staff said, “This really does affect staff morale. We’re always giving, and we never get back.” Staff said this practice was indicative of a lack of communication from senior management, who they felt did not understand the pressures on the service of the nature of the risk in running an understaffed service. Staff gave numerous examples of patients being admitted without a medical assessment and against the wishes of the nurse in charge overnight to ease the pressure on acute medicine despite the risk it presented to patients.

Senior staff on ward 6A used a daily bay inspection checklist to monitor the standards of care and management of the environment. Each bed bay or side room underwent this check and the nurse in charge categorised the results using a RAG rating (red, amber, green). During our weekend inspection, we observed two bays had been rated red due to missing or a low standard of checks. The nurse in charge had spoken with the nurse responsible for each bay that fell short and set them targets for immediate improvement. They noted this tool helped to established standardised quality of practice in an environment that saw a lot of temporary staff delivering care.

The matron for respiratory medicine had implemented a workforce plan to address long-term staffing. They had worked with the trust to change the balance of nurses in the ward to ensure there was always senior cover for patients with high levels of need.

A quality matron provided oversight of the SQD and supported ward teams to implement improvement plans.

Various processes and groups were in place across specialist medicine. For example, the corporate head of nursing and a respiratory physician led a non-invasive ventilation quality group that worked to improve care standards.

Appropriate procedures were in place to prevent unsafe discharges. However, staff said they felt discharges were often rushed by colleagues under pressure to free up inpatient beds. All staff involved in delivering care could stop a discharge where they felt this was unsafe. For example, physiotherapists told us if they felt a discharge was premature and would result in readmission, they would delay discharge until a community care plan could be established and necessary equipment was place in the patient’s home.

The senior site team attended daily bed and operations meetings to maintain an oversight of operational issues, including bed capacity and staffing. We attended one meeting and found the trust had a demonstrable focus on another hospital. There was limited evidence senior teams placed priority on this hospital and there was a clear sense of apathy amongst local staff when there was no resolution to persistent short staffing. Senior staff at the trust’s other site did not demonstrate an understanding of local challenges and did not offer tangible support. Senior ward staff said they rarely challenged decisions made by the site team because they were not listened to and usually overruled, despite clear implications for patient safety.

We spoke with junior doctors who had submitted incident forms regarding unsafe staffing levels out of hours. They said they had not received a response to the incident reports despite one resulting in an overnight delay to over 15 patients being seen by a doctor. Interfaces between medical specialties meant there were gaps in responsibility of care that delayed treatment. For example, systems and records for requesting a transfer and communications between specialties were not always robust. As a result, patients were often missed for review.

Clinicians did not always involve the wider team when making decisions that affected patient care or the operation of the service. For example, a stroke consultant had implemented a new
requirement that patients presenting in the emergency department (ED) must be clerked there before they could be admitted to the stroke ward. However, stroke consultants did not routinely attend the ED, which meant patient stay was extended. Systems to identify patients awaiting specialist review in the ED were not fit for purpose. A stroke nurse was scheduled to contact the ED every two hours to ask if any patients were awaiting review because stroke consultants could not be contacted directly or proactively from ED. Staff said it was a frequent occurrence that the ED team would note there were no patients awaiting review only for a patient to emerge hours later who had been missed. There was no evidence the senior divisional team was aware of this.

The trust demonstrated they were aware of significant staffing shortfalls in the SaLT team, who worked for another NHS trust and worked in the hospital through a service level agreement. However, there was no coherent or robust plan in place to address this, despite the trust’s understanding that not all patients who needed a SaLT review were seen. The trust did not have reliable data on how low staffing levels impacted patient care but noted that over 78% of patients who needed a SaLT review prior to discharge did not receive this.

The sepsis practitioner maintained a record of each ward’s performance in three key sepsis screening standards. This included a completed sepsis screen, administration of antibiotics within 60 minutes and the use of the Sepsis 6 pathway. Between May 2018 and May 2019, there was very limited evidence of a trajectory of improvement. All areas we included in the medical care inspection performed with high variability and failed to achieve the minimum 90% compliance standard on at least three occasions in the recording period. Standards of completion of sepsis screens were exceptionally poor. For example, in this period the AMSS screened only 70% of patients and met the 90% minimum standard in one month, July 2018. In April 2019 only 33% of patients were screened. Wards 7B, 8A, the stroke unit and the IAC did not meet the minimum 90% target in any month during this period. Ward 6A demonstrated potential short-term improvement with screening increasingly steadily from 63% in February 2019 to 100% in April 2019. However, this dropped to 91% in May 2019. There were only nine occasions, out of a potential 115, where wards also achieved the minimum standard for antibiotic administration and use of the pathway where they also achieved the standard for screening. In some cases overall performance was very low. For example, in April 2019, ward 7B achieved just 29% compliance with sepsis screens and achieved 0% for the administration of antibiotics and the completion of the Sepsis 6 pathway. In some instances staff completed 100% of sepsis screens but failed to administer timely antibiotics or implement the pathway. For example, in June 2018 the ACU achieved 100% for sepsis screening an 0% for antibiotics and use of the pathway. In November 2018 the chemotherapy suite had the same results. The chemotherapy suite and the endoscopy unit were the only two areas to achieve more than two consecutive 100% results for completion of sepsis screening. The chemotherapy suite achieved this in every month from December 2018 and the endoscopy unit achieved it in every month from January 2019.

The trust had implemented a quality and safety improvement plan for the deteriorating patient and sepsis. This included a structured plan to improve screening and treatment compliance, with a completion date of December 2018. There was no evidence this plan had resulted in improvements to sepsis management.

Information management

The service did not collect data that was always reliable. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
In some areas, there was a lack of assurance of data quality. For example, the response rates for some wards in the NHS Friends and Family Test were low, for example wards 7B and 8A had response rates of 17%. This meant the results had reduced impact. In addition, ward 6B reported a response rate of over 100%, which suggests issues with data quality.

Staff in a number of clinical areas described paperwork procedures as duplicitous and laborious. The IAC had a working group to address these issues. For example, the team said some documentation had not been reviewed for several years and they were updating this as part of the project.

**Engagement**

*Leaders did not always actively or openly engage staff. Ward-based teams engaged with patients and colleagues to plan and manage services. They collaborated with partner organisations to help improve services for patients.*

The team on ward 6B had created a highly visual ‘pride tree’ display that included quotes from staff about what they were most proud of in their work. This was accessible to anyone visiting the ward and three relatives we spoke with said it had reassured them about the passion of the team for their work.

There were gaps in engagement between the trust and staff. For example, staff were frequently unaware of trust initiatives or changes to the service. AHPs said they were unaware why the trust had discontinued a seven-day service trial of dietetics, which they said had been successful. Nurses and other clinicians said the pain management team had been disbanded without warning and they had spent considerable time trying to contact the team before being told they were no longer in post.

A deputy director of operations had worked to improve relationships and engagement with social care and community providers by establishing working groups.

Improving how patients and staff were involved in shaping services was a key element of the trust’s 2021 strategy and included the need to ensure learning from patients’ experiences was acted on.

The new leadership team for medical care planned to involve staff in the significant improvement strategies needed in the service. The team said they were in the process of speaking with staff to gather ideas for specific service improvements and for the lessons individuals had learned through reflective practice. The team had approached consultants initially and said they found senior clinicians to be supportive of major changes. Through this process, the new team had identified gaps in medical leadership in the stroke service. For example, locum consultants had shown a reluctance to convert their contracts to permanent posts and had worked with them to address their concerns. The team had also introduced a series of engagement activities with staff, which led to changes to the induction process to provide staff with more support to meet their colleagues and build good working relationships.

In some services, on-going staff vacancies were the primary concern and meant there was little capacity to focus on other areas. In the oncology and haematology service, a senior member of staff said, “All recruitment initiatives have been exhausted”, and said they did not foresee a sustainable future for the service.

A dedicated team had led an involvement plan for the TOM programme, which had included structured engagement with staff and patients affected by the changes. This included the opportunity for staff to meet with the implementation team to discuss concerns or provide feedback. As part of the engagement plan, a masterclass was offered to key staff to help them understand the planned changes and contribute to development. Uptake was very low and only 14
staff were recorded as attending, out of the 45 individuals invited from across all of specialty medicine, therapies and cancer services.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Despite persistent short-staffing and low morale in some services, the trust was demonstrably focused on improving access and flow and their ability to meet patient's needs. For example, the trust was one of only four nationally to have established an integrated assessment centre (IAC) to support the patient transition from the emergency department to an inpatient ward.

The AHP team planned to redesign care pathways to develop services into the community once they had resolved staff shortages. This work was underway in part and the occupational therapy team had completed work with the relatives of patients living at home with dementia to help them provide more individual support. The team was also planning virtual clinics, such as a fracture clinic, to follow up patients by phone or video chat to limit unnecessary follow up appointments.

A multidisciplinary falls clinic was in the planning stage, led by a frailty consultant. This provided shared learning opportunities for staff, who had attended a series of pathway design events.

AHPs used the freedom the trust offered them to trial and develop services. Staff said they could think less rigidly about service design and instead by innovative and brave in developing new strategies. For example, band five therapists had helped redesign services by choosing their own rotations to take ownership of their work. Senior staff said this had improved retention as a result.

Senior staff had acted on results from staff surveys and redesigned appraisals as a result. The new versions were shorter and less time-consuming and enabled staff to focus on key objectives.

The AHP team had implemented a talent academy and a work experience programme for students from local schools. This was part of a long-term strategy, in partnership with school career professionals, to secure a future workforce. As part of this, the team had launched social media campaigns to raise awareness of the hospital and the team’s work and made training videos available to help young people understand the work of staff.

Senior AHP staff had developed a ‘grow your own’ strategy to address the persistent levels of short staffing. This included developing therapy assistants through apprenticeships, with incentives to remain in the hospital once qualified. We spoke with a therapy assistant about this who said it was a positive opportunity to help their professional development.

The new senior leadership team for medicine had introduced a series of workstreams to improve inpatient flow. As part of this work they had identified 25 principles of good practice and had trialled a day of operating flow through the service in accordance with these. The team said the trial had been successful as part of work towards the national ‘getting it right first time’ (GIRFT) programme and they planned to fully introduce it shortly after our inspection.

Senior teams were in the early stages of integrating remote video technology to enable staff working cross-site to meet and communicate more easily. This enabled matrons working in the new structure to work cross-site and maintain regular contact with their teams. In addition, the team said they had organised away days to bring staff together and help integrate new working models. However, none of the staff we spoke with mentioned any of these initiatives when asked about trust relationships and future strategy.
A clinical specialist consultant was the frailty lead based cross-site and was working to establish an integrated frailty service. They had led a pilot scheme from January 2019 to establish how best to meet patient’s needs. Staff involved felt this had been a successful pilot and they hoped the trust would permit its permanent establishment shortly after our inspection. The trial had reduced length of stay and identified the need for more work to reduce falls risks. The trial had also improved communication and relationships with community therapists.

The oncology team had implemented a mobile chemotherapy unit as well as prostate therapy for inpatients and a nurse-led venesection service.

The AHP team had introduced a cross-system forum to help share good practice and reduced the pressure from on-going short staffing. The Chief AHP Officer had recognised this as good practice and shared it nationally.

Each ward team displayed an improvement calendar that was intended to be completed daily to highlight opportunities for improvement in the department and to recognise recent accomplishments. For example, the team on ward 6A noted their recent successes as improved compliance with mandatory training and appraisals. The team noted recent daily discussions had been on infection control and ward leadership and their goals were to improve consistency of sepsis screening and fluid balance documentation. This was indicative of the work each ward team completed to improve standards of care and we saw consistent use of this tool, with the exception of the endoscopy unit.

Relationships with Lincoln County are developing, with mutual visits happening or planned. Lincoln County is considering developing the IAC model. There are only 3 other IACs in the country.
## Facts and data about this service

The trust has 33 critical care beds. A breakdown of these beds by type is below.

### Breakdown of critical care beds by type, United Lincolnshire Hospitals NHS Trust and England

<table>
<thead>
<tr>
<th></th>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>8.1%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Adult</td>
<td>93.9%</td>
<td>70.3%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Descriptions of the critical care service at each site at the trust is below:

### Lincoln County Hospital

The hospital has an intensive care unit with 16 beds to manage level 2 (HDU) and level 3 (Intensive Care Unit (ICU)) critically ill patients. The unit is staffed by a team of consultant intensivists supported by registrars on rotation from Nottingham and Leicester. The nursing staff are led by a team of senior sisters.

### Pilgrim Hospital

The hospital has an intensive care unit (ICU). Senior medical advice on site supports rapid decision making and early commencement of treatment.

(Source: Trust website)

The critical care unit at Pilgrim Hospital has nine beds for level 2 and level 3 patients.
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 service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training, with the exceptions of:

- Fraud awareness and infection prevention level one, which had targets of 95%.
- Local fire procedures and fire safety, which had targets of 100%.
- Immediate life support (ILS)/advanced life support (ALS) and medicine management training which had no targets. The trust informed us that the eligible numbers of staff were not available for these two courses and therefore we were unable to calculate completion rates.

Trust level

A breakdown of compliance for mandatory training courses as of February 2019 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>112</td>
<td>116</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>111</td>
<td>116</td>
<td>95.7%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>111</td>
<td>116</td>
<td>95.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>110</td>
<td>116</td>
<td>94.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>109</td>
<td>116</td>
<td>94.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>108</td>
<td>116</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>108</td>
<td>116</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>108</td>
<td>116</td>
<td>93.1%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>108</td>
<td>116</td>
<td>93.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>105</td>
<td>116</td>
<td>90.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>102</td>
<td>116</td>
<td>87.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>36</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>72</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

In critical care the target was met for seven of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.
A breakdown of compliance for mandatory training courses as of February 2019 at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>14 14</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>13 14</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>13 14</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>13 14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>13 14</td>
<td>92.9%</td>
<td>100%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>13 14</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic life support</td>
<td>13 14</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>12 14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>12 14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>12 14</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>12 14</td>
<td>85.7%</td>
<td>100%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In critical care the target was met for five of the 11 mandatory training modules for which medical staff were eligible.

**Pilgrim Hospital critical care department**

Nursing staff received and kept up to date with their mandatory training.

A breakdown of compliance for mandatory training courses as of February 2019 for qualified nursing staff in the critical care department at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>49 52</td>
<td>94.2%</td>
<td>100%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>49 52</td>
<td>94.2%</td>
<td>95%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>49 52</td>
<td>94.2%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic life support</td>
<td>48 52</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>48 52</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>48 52</td>
<td>92.3%</td>
<td>100%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>48 52</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>47 52</td>
<td>90.4%</td>
<td>95%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>46 52</td>
<td>88.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>45 52</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>45 52</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>7 0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine management training</td>
<td>39 0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At Pilgrim Hospital's critical care department, the target was met for three of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

Managers for nursing staff monitored mandatory training and alerted staff when they needed to update their training.

The clinical nurse educator in the critical care unit at Pilgrim Hospital told us the figures included staff on long term sick which made the figures appear lower than the actual rate. We saw...
records to confirm that nursing staff had either completed their mandatory training or were booked on to attend training.

Medical staff received and kept up to date with their mandatory training.

A breakdown of compliance for mandatory training courses as of February 2019 for medical staff in the critical care department at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>6</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>6</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>6</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>6</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>6</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>6</td>
</tr>
<tr>
<td>Basic life support</td>
<td>6</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>5</td>
</tr>
<tr>
<td>Fire safety</td>
<td>5</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>5</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital’s critical care department, the target was met for eight of the 11 mandatory training modules for which medical staff were eligible. However, the completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.

Managers of medical staff monitored mandatory training and alerted staff when they needed to update their training.

The critical care unit had a consultant who led on medical staff training who ensured all eligible staff attended mandatory training. We spoke with the consultant who said all medical staff who were at work and required mandatory training had completed it or were booked on to attend.

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

Staff received annual training on sepsis management which included the use of sepsis screening tools and use of the sepsis care bundle.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning, disabilities, autism and dementia. Staff told us they had completed training which provided them with awareness on supporting patients with these needs.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

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

Trust level

A breakdown of compliance for safeguarding training courses as of February 2019 at trust level
for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>101</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>101</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>100</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>100</td>
</tr>
</tbody>
</table>

In critical care the 90% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as of February 2019 at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>12</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>12</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>12</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>12</td>
</tr>
</tbody>
</table>

In critical care the 90% target was not met for any of the four safeguarding training modules for which medical staff were eligible.

**Pilgrim Hospital critical care department**

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of February 2019 for qualified nursing staff in the critical care department at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>41</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>41</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>40</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>40</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital’s critical care department, the 90% target was not met for any of the four safeguarding training modules for which qualified nursing staff were eligible.

The clinical nurse educator for the critical care unit told us that the figures included staff on long term sick which would make the figures appear lower than the actual figures. We saw records that showed eligible staff had either attended training or were booked on to attend training.

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of February 2019 for medical staff in the critical care department at Pilgrim Hospital is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>5</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>5</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>5</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>5</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital’s critical care department, the 90% target was not met for any of the four safeguarding training modules for which medical staff were eligible. However, completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates. All modules needed one more staff member trained to have a 100% completion rate.

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

The critical care unit consultant lead on medical staff training ensured all eligible staff attended mandatory training.

Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us they had a heightened awareness of safeguarding issues due to the fragility of their patients. One member of staff explained that if a patient had bruising that was not in line with their accident or other injuries, they would make a safeguarding referral.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. Staff could refer patients to the hospital safeguarding team.

Staff followed safe procedures for children visiting the ward. Staff told us that a health care support worker could stay with a child in the visitor’s room if a parent was visiting their relative in the unit. This was to protect the child from the distressing experience of seeing their loved one receiving critical care support.

There were arrangements in place to safeguard women or children with, or at risk of, Female Genital Mutilation (FGM). We spoke with a member of nursing staff who confirmed this was covered in safeguarding training and staff were aware of signs of FGM.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained. Staff used control measures to prevent the spread of infection. Patients who had an infection could be barrier nursed in side rooms which had a separate gowing area for staff and visitors.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. The service had domestic staff who managed the cleaning of the critical care unit. The ward manager told us that daily cleaning was very thorough for infection control. We saw staff completed a daily list of cleaning tasks to ensure all areas were cleaned.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff had used “I am clean” stickers to place on equipment with the date of cleaning.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff we bare below the elbow and carried out hand hygiene such as hand washing.
and using gel. Where a patient was isolated in a side room due to having an infection, staff used aprons and gloves to provide care for the patient.

The intensive care national audit and research centre (ICNARC) Quarterly Quality Report 1 April 2018 to 30 September 2019 showed, for Pilgrim Hospital, an expected rate of unit acquired infection in the blood in critical care. This was in line with the national comparator.

Managers told us incidents such as catheter and ventilator associated infection would be discussed by managers and consultants, so they could take action to reduce infections.

**Environment and equipment**

*The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.*

The design of the environment followed national guidance. The unit had sufficient medical equipment to enable staff to provide critical care for patients. Staff cared for patients one to one and could offer excellent personal care and support. There was a hospital equipment department that ensured equipment was readily available. The unit had recently had new beds and ventilators which staff said had improved patient care.

Staff carried out daily safety checks of specialist equipment. We looked at over 20 different pieces of equipment and all were up to date with servicing. We saw that staff carried out daily checks of resuscitation trolleys. Managers attended a monthly clinical governance meeting where any equipment issues were discussed.

The service had suitable facilities to meet the needs of patients’ families. Families and friends could visit patients for two hours in the afternoon and an hour and a half in the evening. The unit had a comfortable and well-equipped visitors’ room. There was also a quiet room for private conversations with medical and nursing staff.

Staff disposed of clinical waste safely. Clinical waste was managed effectively and was collected regularly to prevent it building up in the units.

**Assessing and responding to patient risk**

*Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.*

Staff completed risk assessments for each patient on admission and updated them when necessary. Staff used an electronic clinical information system (CIS) to record patient risk assessments which had guidance included to enable staff to quickly carry out assessments and put any measures in place to keep people safe. We looked at four electronic patient records in detail and saw that staff completed comprehensive risk assessments such as manual handling, cannula care (a thin tube inserted into a vein or body cavity to administer medication or drain off fluid), ventilator tube care, pain, falls and nutrition.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used CIS to record patient observations. Staff could view records quickly in case of any sudden changes to a patient’s medical condition. Staff were prompted by the system if any of the observations triggered the need for further concern and immediate input from a doctor. Staff continuously monitored the vital signs of patients. Immediate treatment for sepsis was provided by the emergency department. The critical care unit received and continued treatment for critically ill patients with sepsis. Staff used CIS to record observations and monitor treatment for sepsis.
As nursing staff cared for patients one to one or two to one, they provided an immediate response to patient deterioration.

As recommended by NHS England, the service had developed local safety standards for invasive procedures (LocSSIPs). The standards set out a checklist for staff when caring for patients undergoing invasive procedures.

The critical care outreach team played a vital role in the assessing and responding to patient risk across the hospital. The critical care outreach team ran 24 hours a day, seven days a week. The team offered critical care support for patients across the hospital so that patients could stay on a ward specialised for their specific medical condition.

The critical care outreach team provided tracheostomy care for patients in other wards across the hospital. Staff completed a tracheostomy review form for patients moving to a ward from critical care with a tracheostomy. The critical care outreach team visited patients within 24 hours of moving to the ward. The team carried out a follow up review and offered advice to ward staff.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff could refer patients when they had concerns about their mental health. Staff told us the mental health team within Pilgrim Hospital was very good and attended the unit to assess patients when necessary.

Shift changes and handovers included all necessary key information to keep patients safe. We observed a multidisciplinary ward hand over meeting where each patient’s needs were discussed. We saw consultants, registrars, junior doctors, a dietician, ward manager, an outreach team nurse and physiotherapist attended the meeting. The attendees discussed individualised care for each patient to ensure their best treatment and recovery taking into account all the professional opinions.

A pharmacist was not always available for daily ward handover meetings and therefore could not have consistent oversight on each patient. This was below the Core Standards for Intensive Care Units which stated clinical pharmacy services should include attendance at consultant-led multidisciplinary ward rounds.

Staff shared key information to keep patients safe when handing over their care to others. Discharges to wards from critical care were planned before 8pm to ensure the critical care outreach team was available to visit the patient if necessary. Any transfers after 10pm were reported through the trust’s electronic incident reporting system. The critical care outreach team worked with the wards to provide practical learning and advice for ward staff on patient care procedures when moving to their ward from critical care. Staff provided hand over information about patients to ward staff on paper discharge forms.

When staff discharged a patient, they provided a discharge summary for the patient to take with them. The service sent discharge summaries to patients’ GPs, including information about post intensive care syndrome (a cognitive, psychiatric and/or physical disability developed after treatment in intensive care unit). Patients were invited to contact the service if they needed any advice following discharge.

There was additional space available for three more critical care beds in case of a sudden increase in critical care admissions.

**Nurse staffing**
The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.

The service mostly had enough allied health professionals with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Trust level

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for critical care.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>63.7</td>
<td>72.4</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>47.5</td>
<td>47.1</td>
</tr>
<tr>
<td>Total</td>
<td>111.2</td>
<td>119.4</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the nursing staffing rate within critical care was 93.2%. This was higher than the rate of 89.8% in the more recent period from April 2018 to February 2019.

Pilgrim Hospital

Pilgrim Hospital reported the following WTE nursing staff numbers for the periods below for critical care.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Critical care outreach</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Intensive care unit</td>
<td>47.5</td>
<td>47.1</td>
</tr>
<tr>
<td>Total</td>
<td>47.5</td>
<td>47.1</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the nursing staffing rate within critical care at Pilgrim Hospital was 101.0%. This was higher than the rate of 90.3% in the more recent period from April 2018 to February 2019.

Figures higher than 100% indicate there were more WTE in post than originally planned.

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

Vacancy rates

Trust level

From April 2018 to March 2019, the trust reported a vacancy rate of 8.6% for nursing staff in critical care. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital critical care department: 10.8%
- Pilgrim Hospital critical care department: 5.7%
Pilgrim Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care outreach</td>
<td>35.8%</td>
</tr>
<tr>
<td>Intensive care unit</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

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

We spoke with a critical care outreach team (CCOT) staff member who told us the service had recruited two new members of staff to CCOT in the last month. The CCOT team consisted of nine members of staff which meant the vacancy rate was high from the previous two vacancies which had been filled at the time of the inspection.

Turnover rates

Trust level

From April 2018 to March 2019, the trust reported a turnover rate of 4.7% for nursing staff in critical care. This was lower than the trust target of 8%.

- Lincoln County Hospital critical care department: 4.0%
- Pilgrim Hospital critical care department: 5.7%

Pilgrim Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care Outreach</td>
<td>16.4%</td>
</tr>
<tr>
<td>Intensive care unit</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

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

Sickness rates

Trust level

From April 2018 to March 2019, the trust reported a sickness rate of 4.5% for nursing staff in critical care. This was the same as the trust target of 4.5%.

- Lincoln County Hospital critical care department: 4.2%
- Pilgrim Hospital critical care department: 5.0%

Pilgrim Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive care unit</td>
<td>5.2%</td>
</tr>
<tr>
<td>Critical Care Outreach</td>
<td>2.3%</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

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

The Matron for the Pilgrim Hospital critical care unit told us the service’s turnover and sickness rate at the time of the inspection was below the trust average.

Bank and agency staff usage
Trust level

The table below shows the numbers and percentages of nursing hours in critical care at trust
level from March 2018 to February 2019 that were covered by bank and agency staff or left
unfilled.

Of the 233,513 total working hours available, 2.8% were filled by bank staff and 3.3% were
covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 11.5% of the available hours with either bank or
agency staff.

Of the 24,345 total working hours available, 27.1% were filled by bank staff and 0.0% were
covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 47.2% of the available hours with either bank or
agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified staff</td>
<td>233,513</td>
</tr>
<tr>
<td>Non-qualified staff</td>
<td>24,345</td>
</tr>
</tbody>
</table>

Pilgrim Hospital

The table below shows the numbers and percentages of nursing hours in critical care at the one
critical care unit in Pilgrim Hospital from March 2018 to February 2019 that were covered by bank
and agency staff or left unfilled.

Of the 92,001 total working hours available, 3.1% were filled by bank staff and 0.2% were
covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 13.5% of the available hours with either bank or
agency staff.

Of the 8,721 total working hours available, 9.4% were filled by bank staff and 0.0% were
covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 56.5% of the available hours with either bank or
agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified staff</td>
<td>92,001</td>
</tr>
<tr>
<td>Non-qualified staff</td>
<td>8,721</td>
</tr>
</tbody>
</table>

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

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants
and healthcare assistants needed for each shift. In accordance with national guidance.

The critical care unit had one nurse for each patient as patients required high level support.
Handover for nursing staff was twice a day at 7am and 7pm. Staff discussed every patient to ensure all staff were kept informed. The service also health care support workers to support nursing staff, to care for patients and support family members.

Physiotherapy staffing was adequate to provide the respiratory management and rehabilitation. Physiotherapists saw every patient every day to provide support with movement and chest checks. A physiotherapist told us there were enough staff to meet the needs of patients.

Speech and language therapists (SALT) were not always available to review patients for swallowing assessments which could cause a delay for patients weaning onto oral feeding. This did not meet the Core Standards for Intensive Care Units which stated all patients with a tracheostomy should have communication and swallowing needs assessed when the decision to wean from the ventilator has been made and the sedation hold has started. A shortage of speech and language therapists was a known issue nationally. Managers for the service told us they were planning to train nursing staff to be able to carry out swallowing assessments to prevent a delay in recovery for patients. We saw plans were already underway for the clinical nurse educator to attend training to be able to train nursing staff to complete the assessments and meet the national standards.

### Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.

### Trust level

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for critical care.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>9.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>7.0</td>
<td>8.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16.0</strong></td>
<td><strong>18.0</strong></td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the medical staffing rate within critical care was 89.0%. This was higher than the rate of 83.4% in the more recent period from April 2018 to February 2019.

As there was only one team based at each site, these are represented in the site breakdown above.

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

### Vacancy rates

### Trust level

From April 2018 to March 2019, the trust reported a vacancy rate of 18.9% for medical staff in critical care. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.
• Lincoln County Hospital critical care department: 16.5%
• Pilgrim Hospital critical care department: 21.9%

Both sites just had the one department reporting vacancies. These are detailed above.

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

Turnover rates

Trust level

From April 2018 to March 2019, the trust reported a turnover rate of 10.0% for medical staff in critical care. This was higher than the trust target of 8%. The trust has reported that their turnover data for medical staff includes trainee grades which may have inflated the rate.

• Lincoln County Hospital critical care department: 5.9%
• Pilgrim Hospital critical care department: 15.4%

Both sites just had the one department reporting turnover. These are detailed above.

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

Sickness rates

Trust level

From April 2019 to March 2019, the trust reported a sickness rate of 2.4% for medical staff in critical care. This was lower than the trust target of 4.5%.

• Lincoln County Hospital critical care department: 0.9%
• Pilgrim Hospital critical care department: 4.3%

Both sites just had the one department reporting sickness. These are detailed above.

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

Bank and locum staff usage

Please note that the trust confirmed that they were unable to provide accurate establishment hours by department and location in all cases. Therefore, we have not calculated the proportion of hours filled by bank and locum staff or left unfilled as this may be misleading.

Trust level

The table below shows the number of medical hours in critical care at site level from April 2018 to February 2019 that were covered by bank and locum staff or left unfilled.

Over this time period, 2,775 hours were filled by bank staff and no hours were covered by locum staff to cover sickness, absence or vacancy for medical staff. The trust was not able to fill 487 of the available hours with either bank or locum staff.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank usage</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>2,775</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>0</td>
</tr>
</tbody>
</table>
Pilgrim Hospital

As there was only one team based at this site, the table above shows the number of medical hours in critical care at Pilgrim Hospital from April 2018 to February 2019 that were covered by medical and locum staff or left unfilled.

Over this time period, no hours were filled by bank or locum staff to cover sickness, absence or vacancy for medical staff. The trust was unable to fill 221 of the available hours with either bank or locum staff.

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

The service had enough medical staff to keep patients safe. The Pilgrim Hospital critical care unit was led by consultants in intensive care medicine. There was always a consultant on duty for the unit. The ratio for consultants to patients in the day was within the expected range of one consultant for fifteen or less patients. There were two to three trainee doctors on duty seven days a week.

Consultants reviewed patients each morning attended the multidisciplinary ward handover meeting at 8am and carried out a morning ward round. Consultants carried out ward rounds twice daily in the week and once a day at weekends.

We spoke with a critical care consultant who explained that recruitment and retention of doctors was an issue due to the isolated location of the hospital. Manager told us the service continuously worked on recruitment of doctors to the service.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, recent audits of electronic patient records on the clinical information system (CIS) had found staff were not always completing patient records such as oral care and tissue viability assessments.

Patient notes were comprehensive, and all staff could access them easily. We reviewed in detail four patient records on the electronic CIS system which were completed thoroughly, were up to date and were accessible for staff. Staff used CIS to record observations of patients to enable a quick reference for all staff due to the vulnerable condition of the patients.

Staff provided hand over information about patients to ward staff on paper discharge forms.

Records were stored securely on the electronic system requiring password access.

We saw recent audit results for oral care and tissue viability assessment recording in CIS. These showed staff were not always ticking the appropriate boxes electronically. Managers told us staff were completing tasks and assessments but not ticking the correct boxes in the system. We saw managers had taken action to discuss these issues with staff and recording had improved between April and May 2019. However, the work was ongoing to ensure staff recorded oral care and tissue viability assessments in CIS 100 percent of the time.

Medicines
The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines.

The Trust’s critical care pharmacist and other clinical pharmacists visited the unit to review patients’ medicines. However, the pharmacy service fell below the standards of GPICS (Guidelines for the Provision of Intensive Care Services) as the critical care pharmacist normally spent one day a week on the unit, as opposed to a minimum of five days pharmacy cover per week as advised by the guidance. During the week of our inspection, the pharmacist did not attend the unit. Staff we spoke with did not know when other pharmacists were coming. However, the pharmacist had a trainee pharmacist with the intention to fulfil this role and to meet the standards.

The out of hours on-call pharmacist was not always able to attend the unit from home to dispense urgently required medicine. During our inspection there was an incident where the out of hours on call pharmacist was required to attend the critical care unit to dispense urgently required medicine for a patient. The pharmacist could not attend the unit which led to a delay in the medicine being available for the patient. The patient was not harmed following the incident. Staff submitted an electronic incident report and made managers aware of the incident. Senior managers told us they would look into the incident and prevent any re-occurrence.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service used an electronic clinical information system (CIS) to record medicines prescribed, required and administered. The system used helped to keep patients at a lower risk of medication errors. Staff explained that CIS described the required medicine and dosage for patients depending on the information staff inputted.

We looked at seven medication records on CIS and saw that staff had recorded allergies, and antibiotic prescribing and administration had been clearly documented. Patients’ medicines were reviewed by medical staff with input and advice from the critical care pharmacist.

Staff recorded in patient records when patients were prescribed an antimicrobial including the reason for the medicine, the dose and duration of treatment. Patients had regular antimicrobial samples taken and their treatment was reviewed when results were available.

Out of four prescription charts we looked at, three had not had medicine reconciliation checks by a pharmacist.

Medicines were stored securely and at the right temperatures and staff monitored stock levels.

Pharmacists for critical care worked between Lincoln County Hospital and Pilgrim Hospital. Managers at Pilgrim Hospital told us the agreed input from the pharmacy team was to attend the unit one day a week to review patient medicines.

Decision making processes were in place to ensure patient’s behaviour was not controlled by excessive and inappropriate use of medicines. We saw staff used medicines for sedation appropriately in response to clinical need.

**Incidents**

**The service managed patient safety incidents well.** Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
Staff knew what incidents to report and how to report them. Staff received feedback from investigation of incidents.

We spoke with a nurse who explained staff were encouraged to report incidents on the trust electronic system. They said they had reported an incident and received feedback in person from a manager. Another nurse also told us they had reported an incident and had received feedback. We saw managers had displayed a notice in the staff room to remind staff of the incidents which must be reported through the incident reporting system.

**Never Events**

The service had no never events.

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

From March 2018 to February 2019, the trust reported no never events for critical care.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from March 2018 to February 2019.

A breakdown of the serious incidents by type is shown in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer</td>
<td>5</td>
<td>55.6%</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>2</td>
<td>22.2%</td>
</tr>
<tr>
<td>HCAI/infection control incident</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td><strong>Trust-wide</strong></td>
<td><strong>9</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Pilgrim Hospital**

In accordance with the Serious Incident Framework 2015, Pilgrim Hospital reported seven serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from March 2018 to February 2019:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>5</td>
<td>71.4%</td>
</tr>
<tr>
<td>HCAI/Infection control incident</td>
<td>1</td>
<td>14.3%</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>1</td>
<td>14.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))
Managers investigated incidents thoroughly. The Pilgrim Hospital critical care unit had a lead consultant for governance and risk and led a monthly meeting where incidents were discussed. A ward manager showed us an electronic dashboard for monitoring incidents. The matron and ward managers led on incident investigations with input from staff leading in the specific area of patient care. The service had a consultant who led on medical incident investigations.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers and staff spoke about duty of candour and how they informed and involved families following incidents.

Staff met to discuss the feedback and look at improvements to patient care. Staff told us they had monthly staff meetings were any incidents were discussed. We saw managers displayed learning points on the staff noticeboard in the staff room.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

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 three new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from March 2018 to March 2019.

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

<table>
<thead>
<tr>
<th>Total Pressure Ulcers (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

1 Pressure ulcers levels 2, 3 and 4

(Source: NHS Digital)

Safety thermometer data was displayed on the Pilgrim Hospital critical care unit for staff and patients to see. This showed the service’s results each month for number of pressure ulcers, falls and urinary tract infections (UTI).

Staff used the safety thermometer data to further improve services. Results were discussed at monthly risk and governance meetings. We saw learning following the monitoring of pressure ulcers. Staff had identified a delay in the removal of sutures following a tracheostomy (a tracheostomy is an opening created at the front of the neck so a tube can be inserted into the
windpipe to help the person to breathe). A delay in the removal of sutures could increase the risk of the patient acquiring a pressure ulcer. Managers had implemented a new system of a laminated card next to each tracheostomy patient’s bed with the suture removal date to remind staff.

The service collected rates on catheter associated infection as part of their surveillance programme. Results were reviewed by staff and where applicable improvements in ways of working were put into practice with staff.

We saw patient records on the electronic clinical information system included an assessment of venous thromboembolism (VTE) (a condition in which a blood clot forms most often in the veins). We saw staff had recorded where medicine had been prescribed to prevent the formation of blood clots.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Overall staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. However, some policies on the electronic clinical information system (CIS) were out of review date.

Managers checked to make sure staff followed guidance. The service followed national guidance including the guidelines for the provision of intensive care services (GPICS) and the National Institute for Health and Care Excellence (NICE). The Faculty of Intensive Care Medicine (FICM), Intensive Care Society (ICS) and the Royal College of Anaesthetists (RCoA) were three of the organisations that endorsed GPICS.

As recommended by NHS England, the service had developed local safety standards for invasive procedures (LocSSIPs). The standards set out the key steps necessary to deliver safe care for patients undergoing invasive procedures.

We looked at six guidelines on the CIS and found that the tracheostomy policy and sedation hold guidelines were out of review date. We found that the enteral feed guideline was not dated. We spoke with the ward manager who assured us that the policies and guidelines would be reviewed. We saw in the clinical governance meeting minutes for May 2019, the tracheostomy policy review had been discussed. Staff had to present the policy changes to the clinical effectiveness group meeting in July 2019 for approval.

The trust measured compliance with the national standards through local audits presented to the monthly clinical governance meetings. The clinical governance lead consultant and two sisters (one was the service improvement lead) managed local audits. Clinical audits included a ventilator audit looking at volume being ventilated, and a sedation hold audit. Also, junior doctors were completing a combined audit regarding delirium, sleep and sedation. Managers kept an oversight of infection rates of blood borne infection and catheter related infection.

We saw a consultant was leading on a baseline assessment and action plan to ensure staff were following the NICE guideline on anaphylaxis (an acute allergic reaction).

Staff had carried out several local audits to review tissue viability (skin care), sleep and staff compliance with the ventilator care bundle (highlighting oral care for patients). There had also
been an audit of patient handover to doctors in another ward in the hospital following a patient being discharged from critical care.

The ward manager completed daily ward assurance checks, looking at three patients' care. They looked at the patients' records and observed staff at their bedside. Feedback was given immediately to staff and any issues addressed immediately. We saw the ward manager provided the ward health check results for staff on a display in the staff room.

The risk and governance leads made staff aware of any issues following the audits and checked staff were clear about how to implement changes. We saw outcomes were displayed for staff and visitors on noticeboards on the unit.

The service did not have administrative support for risk and governance, such as support for meetings and an audit trail of correspondence and actions. The service's clinical governance monthly meetings and trust wide critical care delivery group bi monthly meetings received no administrative support. There was no assigned administrative staff to support with the coordination of audits, including correspondence with internal and external partners to share information and improve patient outcomes.

The service was part of the Mid Trent critical care network and was active in the development of guidelines for critical care. The Mid Trent network fed into the national critical care network. This ensured the service was always up to date with current critical care best practice.

Staff had access to the trust intranet to access all policies, protocols and procedures.

Staff used very detailed critical care based templates on CIS to ensure patients were not discriminated against on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation avoided when making care and treatment decisions.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff referred patients with mental health needs to the hospital crisis team which was a mental health service. Staff told us the crisis team would visit the unit if necessary and support the patient and provide mental health assessments.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a multidisciplinary handover meeting and saw that staff talked in depth about each patient, including their emotional needs and personal circumstances.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw in three patient records staff had assessed patients using MUST (Malnutrition Universal Screening Tool). Staff had documented in detail fluid intake and output. Staff recorded patients' drained fluid, urine output and fluid balance as part of daily checks. We saw a dietitian had reviewed the patients and medical staff had carried out daily reviews of patients' nutritional needs. If patients were not receiving enough nutrition other methods of feeding could be initiated.

Staff made sure patients had support with nutrition and hydration to meet their needs. They used special feeding and hydration techniques when necessary. We observed staff supported patients during mealtimes with eating and drinking.
Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. There was a designated dietitian assigned to the unit seven days a week. Staff told us there could sometimes be a delay with a speech and language therapist being able to assess patients. This was a national problem of a shortage of speech and language therapists. The service had already taken steps to get a sister trained to carry out swallowing assessments on patients, but this was not yet in place. This sometimes caused delays for patients following tracheostomy removal to moving to swallowing food. Staff managed around the delays and could lead weaning onto foods once the assessment had been carried out.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed four patient records on the clinical information system (CIS) and saw that staff had carried out reviews of patients' nutritional and hydration needs. Where patients could not take fluid or food orally staff clearly documented this in their records. Staff were trained to initiate feeding regimes which was supported through training by the clinical nurse educator. There were regimes in place for feeding through a nasogastric tube (NG tube).

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used an electronic clinical information system (CIS) to record patients’ pain management assessment. We looked at three patient records on the CIS and saw staff used a level three critical care pain tool in line with good practice. Staff observed patients’ facial expression, body movement, vocalisation or compliance with the ventilator and muscle tension to obtain their pain score.

Staff prescribed, administered and recorded all pain relief accurately. In the three patient records we looked at we saw staff had recorded medicines administered for pain relief. We spoke with a patient who said that pain relief had been offered and administered by staff when needed. Another patient said staff had controlled their pain well and had checked their pain levels with them.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits when compared to comparable trusts and managers used the results to improve services further.

**ICNARC Participation**

The trust has two units which contributed to the Intensive Care National Audit Research Centre (ICNARC) – the Intensive Care Units at Lincoln County Hospital and Pilgrim Hospital. This meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))
### ICNARC results

#### Pilgrim Hospital

The table below summarises performance for the Intensive Care Unit at Pilgrim Hospital in the 2017/18 ICNARC Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude non clinical transfers (Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)</td>
<td>0.7%</td>
<td>Within expected range</td>
<td>×</td>
</tr>
<tr>
<td>Crude, non-delayed, out-of-hours discharge to the ward proportion (Discharge out-of-hours is associated with increased risk of mortality)</td>
<td>4.9%</td>
<td>Within expected range</td>
<td>×</td>
</tr>
<tr>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours) (Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day)</td>
<td>6.1%</td>
<td>Not in the worst 5% of units</td>
<td>×</td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio (all patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% (‘lower risk’ patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>0.9</td>
<td>Within expected limits</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

The ICNACR results for the critical care unit at Pilgrim Hospital was within expected limits compared to comparable trusts.

Managers carried out a local audit programme and used information from the audits to improve care and treatment. The service had produced recommendations and action plans for improvement through its audits and had a structure to enable improvements to be made.

Clinical audits included a ventilator audit looking at volume being ventilated, and a sedation hold audit. Other audits included subjects of tissue viability (skin care), sleep and staff compliance with the ventilator care bundle (including oral care for patients).
Outcomes of audits were discussed at the monthly clinical governance meetings and bi-monthly at the trust-wide delivery group meetings. Managers had displayed audit outcomes for staff and visitor in the unit to raise awareness of any ways staff could improve patient outcomes. The service improvement lead had displayed information about the importance of oral care for patients. Managers had put up a poster in the staff room informing staff of the ventilator bundle audit outcome and asking staff to complete the clinical information system (CIS) correctly when oral care was given to a patient.

We could not see evidence that outcomes of audits were benchmarked against NELA (National Laparotomy Audit) and TARN (The Trauma Audit and Research Network).

Improvement was checked and monitored. A ward manager explained that audits were repeated to check for improvement. We saw the tissue viability (skin care) audit had been repeated monthly to check if staff compliance with completing CIS had improved each month.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work.

**Trust level**

From April 2018 to February 2019, 75.7% of staff within critical care department at the trust received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>14</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>12</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>80</td>
</tr>
</tbody>
</table>

**Pilgrim Hospital**

From April 2018 to February 2019, 84.4% of staff within critical care department at Pilgrim Hospital received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>6</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>6</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>42</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
The matron told us that all eligible staff had received an appraisal. Some staff had received their appraisal between February 2019 and the inspection and so were not reflected in the figures. The appraisal figure for the service at the time of the inspection was 98% across the staff groups.

Two staff told us they had received an annual appraisal which was useful to talk about their development and training needs.

Managers gave all new staff a full induction tailored to their role before they started work. This was supported by the clinical nurse educator. New nursing staff were additional to rostered staff for four weeks to allow them to learn the critical care role. New staff observed and carried out tasks with supervision from a colleague mentor. The new staff had two weeks supervised whilst caring for patients. New nursing staff completed a foundation course based on the nationally recognised critical care step one competences. The foundation course consisted of six days within a six month period.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers ensured that staff who were involved in the performance of invasive procedures developed shared understanding and were educated in good safety practice, as set out in the national standards. This was done by the clinical nurse educator who ensured consistency in the competency based on the job training. We saw the clinical nurse educator kept a matrix of training for each piece of equipment and which staff had completed it. This ensured manager could monitor staff competency in using equipment.

The service had additional equipped rooms where the clinical nurse educator could run simulation training with staff, including the use of a dummy. Medical and nursing staff confirmed that there were opportunities to learn and develop. The clinical nurse educator spent one to one days with staff to assess their level of skill and identify any training needs. Staff spoke positively about training offered by the clinical nurse educator, including a five-day course on the acutely ill patient.

Physiotherapists had critical care specific training. There were critical care competencies that they had to achieve.

Following the last inspection, the trust had an action to ensure that 50% of critical care staff had completed the post registration critical care module. This was a minimum requirement in the Core Standards for Intensive Care Units.

Since the last inspection the service had commissioned the course from another trust and accredited by a local university. The course was based on the national critical care competencies, the guidelines for the provision of intensive care services (GPICS). The clinical nurse educator explained that in the next year the service was going back to leading on delivering the course, linking with a different local university they had partnered with previously.

With staff who were due to finish the course in the next few months, the service had 50% of staff who had completed the course. However, there was one member of staff leaving which would slightly reduce the figure. We saw the next course for staff advertised on a display board in the unit. Staff could apply for the next four course places for the next intake. This meant the service could maintain the 50% staff completion rate of the course moving forward.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

A junior doctor told us they had protected time to complete training and training was easily accessible. We saw that the clinical nurse educator had developed a competency list to support managers during one to ones and appraisals. The member of staff could state if they had
completed each competency with a date. If there were any gaps, the clinical nurse educator provided staff with workbooks to use on the job to achieve the competency.

A junior doctor told us they had protected time to complete training and training was easily accessible.

Managers made sure all staff attended team meetings or had access to notes when they could not attend. Staff told us they attended team meeting where incidents and learning were discussed. Staff told us they were sent any important issues by email and so felt well informed if they could not attend the staff meeting.

Managers identified poor staff performance promptly and supported staff to improve. A ward manager explained that verbal feedback was given to staff regularly by managers during daily ward assurance checks. Managers followed trust procedures for staff performance management. We saw that procedures were in place for managers to encourage staff to improve. Following issues identified with mouth care for patients, managers were developing an assessment to carry out with all staff to check understanding and encourage education. A ward manager said where there are issues that continue, managers would look at individual performance to support the member of staff to improve.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary working was evident with staff describing good collaborative working across professions. Medical and nursing staff worked with allied health professionals (AHPs), dietitians and pharmacists. We observed a ward handover meeting where staff from different professions discussed each patient and their complex needs.

We saw in four patient records in the clinical information system (CIS) that doctors, nurses, dietitians and physiotherapists had been involved in the review and planning of patient treatment and care.

A clinical nurse educator was based on the adult intensive care unit and offered on the job advice and training for staff.

Medical and nursing staff worked closely with the organ donation staff in the service. Staff worked across health care disciplines when required to care for patients. Staff liaised well with other disciplines such as surgery, urology and respiratory to enhance patient care and outcomes. Also, consultants discussed long term patients and worked well with other disciplines in the trust to support the patient’s rehabilitation.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff told us they referred patients to the hospital crisis team when they had concerns about the patient’s mental health.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Consultants led daily ward rounds, including weekends. The service had consultants and junior doctor cover during the weekend.
Physiotherapists worked in the service seven days a week and carried out movement and chest reviews of patients every day. Occupational therapists were available Monday to Friday.

There was a critical care pharmacist who worked across sites Monday to Friday. Pharmacist cover at weekends was provided by the pharmacy. Staff told us the pharmacy provided advice on the telephone and any patient medication needs.

Staff on wards could call for support from the critical care outreach team seven days a week. We spoke with a member of the outreach team who said there was always one member of staff on duty in the hospital to support patients on wards who required more intensive care. This enabled patients to stay within a certain speciality to help with their treatment and recovery.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Patients who wished to stop smoking could access support from staff. Larger patients (bariatric) could access dietetic advice from the trust's dietitian service.

We saw the service had recently developed a “discharge from intensive care to the ward” booklet for patients and families. This gave information about rehabilitation, and explained it is normal to experience emotions and a lack of sleep following time in critical care. The leaflet also gave information about nutrition and follow up clinics.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient’s consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We reviewed four sets of patient notes in the clinical information system (CIS). We found where needed, staff had completed capacity assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. In four patient records we looked at we saw consent forms had been completed.

The service had processes for the prevention, identification and reduction of delirium. We saw staff had carried out delirium assessments for patients.

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

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The MCA training delivered covers all levels required and DoLS training is included in the same session so is not reported separately.

Compliance for the MCA/DoLS training course as of February 2019 at trust level for qualified
nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental capacity act</td>
<td></td>
</tr>
<tr>
<td></td>
<td>97</td>
</tr>
</tbody>
</table>

In critical care the target was not met for the MCA/DoLS training module for which qualified nursing staff were eligible.

Compliance for the MCA/DoLS training course at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental capacity act</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
</tbody>
</table>

In critical care the target was not met for the MCA/DoLS training module for which medical staff were eligible.

**Pilgrim Hospital**

Compliance for the MCA/DoLS training course at Pilgrim Hospital for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental capacity act</td>
<td></td>
</tr>
<tr>
<td></td>
<td>40</td>
</tr>
</tbody>
</table>

In critical care the target was not met for the MCA/DoLS training module for which qualified nursing staff were eligible at Pilgrim Hospital.

Medical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Compliance for the MCA/DoLS training course for medical staff in critical care at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
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<tr>
<td>Mental capacity act</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

In critical care the target was not met for the MCA/DoLS training module for which medical staff were eligible at Pilgrim Hospital. However, the completion rate should be interpreted with care as the low number of staff will have impacted on the rate.

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

We spoke with the clinical nurse educator who said that six nursing staff who required the training were booked onto the course.
There was a lead consultant for medical staff training who said all eligible medical staff were up to date with their training.

Managers monitored how well the service followed the Mental Capacity Act and use of Deprivation of Liberty Safeguards. The ward manager carried out daily ward assurance checks of three patients (a third of the bed occupancy in the unit). The ward manager checked the patients’ records to ensure staff had completed the necessary assessments.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with could explain capacity assessment and how to apply the Deprivation of Liberty Safeguards.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Staff paid attention to patients' privacy and dignity when carrying out personal care. We saw staff drew curtains around patient beds when supporting with feeding and personal care. Staff made sure patients were covered with sheets or wore bed clothes to maintain their dignity.

Patients said staff treated them well and with kindness. We spoke with three patients and three relatives and all were very complimentary of the care provided. One relative said the care was “second to none” and the other relatives spoke positively of the care and support they and their loved one had received from staff. Relatives commented that their family member had received “amazing care” and staff spent quality time with them.

The service had recently received the trust’s compassion and respect award. Staff told us they were happy and proud to receive the award. Staff explained it meant a lot to them because the unit had been nominated by a colleague in the hospital.

The service improvement lead had recently carried out a sleep survey to monitor the amount of sleep patients were getting. The results showed patients found it difficult to sleep due to the noise and lights in the unit. Staff created a new sleep pack for patients, including ear plugs and eye mask. Staff told us patients reported positive feedback from the packs and were sleeping better since their introduction.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We spoke with staff about caring for patients with mental health needs. Staff were understanding and spoke about patients with compassion and were not judgemental.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We spoke with staff about patients with cultural and religious needs and staff were mindful and conscious of respected patient’s needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff spent time talking with patients and family members as the care was one to one. We observed a nurse supporting a patient with personal care. The nurse was patient and kind and spent time with the patient to enable them to be independent. Staff encouraged relatives to take breaks and rest to keep themselves well.

We saw the hospital chaplains visited the units to support both patients and families.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The clinical nurse educator for the unit trained and supported staff with difficult conversations. Staff we spoke with were passionate about caring for family members as well as patients. We saw a nurse explaining to a family member why there could only be one visitor by the bedside at any time. The nurse was caring and considerate.

The service offered follow up appointments to eligible patients to offer emotional support following their stay in critical care. This was to improve the quality of rehabilitation for patients. Staff identified patients who had been on a ventilator for more than 72 hours and had been home for three months. Staff invited these patients back to the unit for a follow up appointment. Patients met with medical and nursing staff to look through their patient records and ask any questions.

The service held an annual critical care experience day for patients who had attended follow up clinics. The last day was held in September 2018. Previous patients and their relatives could share their experiences with each other to support each other with recovery.

The service provided bereavement support for family members, including comfort packs for children, and bespoke memory boxes for patient families. Bereavement support was available 24-hours a day seven days a week. Access to specialist nurses were available to provide emotional support for patients and families. We also saw a poster for bereavement booklets available for staff to provide to relatives. The booklet included useful counselling tools, current information for relatives and valuable contact details for further support.

The service had a specialist nurse for organ donation who could speak with families about organ donation.

The service had recently held an opening of a new “tree of life” event. Staff invited family members of patients who had died whilst in the critical care unit to attend. The tree of life was a metal structure placed in the hospital entrance. Commemorative metal leaves were fixed onto the tree with the patient’s name on them.

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

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Staff cared for sedated patients and explained what was happening to the patient as they provided care. Patients we spoke with said staff kept them fully informed of their treatment and discharge plans. Relatives told us staff took time to explain their relative’s health condition and said they were aware of possible outcomes.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We spoke with a patient who told us staff had worked well to support them as they were partially deaf. The patient said staff had given them clear information and explained well. Staff had good access to interpreters when required.
Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients’ families and friends could add comments to a white board in the corridor on the unit. We saw people had added comments such as, “you are all truly amazing and do a wonderful job”, and everyone is, “caring and makes you feel relaxed”.

We saw an online feedback questionnaire that patients could complete when they moved to a ward from critical care. We saw patients had given positive feedback. One patient said they were, “very well looked after and cared for” and “everything was very accommodating”.

The feedback from the Friends and Family Test was positive for the unit. The service collated this data at their patient experience events. A staff member told us staff received cards and gifts from patients as a thanks for the care they received.

### Is the service responsive?

#### Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. An increase in workload for a surgical speciality increased the critical care demand for planned surgery. The service used analysis of trends to plan activity. The managers and consultants had good working relationships with the trust surgical specialities to keep informed about their activity.

The service could offer a room near to the adult critical care unit for patients’ family members to stay at the hospital to be near their family member.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The Matron explained that they kept female patients separate to male patients by having each sex on different sides of the unit.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff told us they could contact the hospital crisis team for support and advice for patients with additional needs. Staff supported patients during follow up meetings who had been discharged from critical care, but their mental health had been affected by the experience. A consultant worked with them to identify the underlying triggers from their time under sedation in critical care.

#### Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Nursing staff completed critical care risk assessments on the clinical information system (CIS) which helped staff to assess each patient’s needs for manual handling, oral hygiene and pressure ulcer risk. In completing the assessments staff could understand any communication issues, physical needs, nutritional needs and level of independence.
Staff supported patients living with dementia and learning disabilities by using ‘all about me’ documents and patient passports. Staff could use an “all about me” booklet to give to patients’ family members so they could provide information about the patient. This enabled staff to understand the patient’s likes and dislikes.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A patient who was partially deaf told us staff supported them well. Staff spoke louder and clearer to ensure the patient could understand.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they could use interpreters for patients whose first language was not English.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The menus offered a variety of choices to meet patient preference. Patients we spoke with confirmed they were happy with the choice of food and drink.

**Access and flow**

**People could access the service when they needed it and received the right care promptly.**

**The service admitted, treated and discharged patients in line with national standards.**

**Bed occupancy**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Patients were reviewed by a consultant in Intensive Care Medicine within 12 hours of admission to the unit.

From March 2018 to February 2019, United Lincolnshire Hospitals NHS Trust's adult bed occupancy fluctuated around the England average. The rates at the trust were generally lower than or similar to the England average.

**Adult critical care bed occupancy rates, United Lincolnshire Hospitals NHS Trust**

![Graph showing adult critical care bed occupancy rates](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

**Delayed discharges**

Managers and staff worked to make sure patients did not stay longer than they needed to.

**Pilgrim Hospital**

The table below summarises performance for the Intensive Care Unit at Pilgrim Hospital in the
### 2017/18 Intensive Care National Audit Research Centre ICNARC Audit.

**Metrics (Audit measures)**

<table>
<thead>
<tr>
<th></th>
<th>Trust performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crude, non-delayed, out-of-hours discharge to the ward proportion</strong> <em>(Discharge out-of-hours is associated with increased risk of mortality)</em></td>
<td>4.9%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td><strong>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours)</strong> <em>(Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day)</em></td>
<td>6.1%</td>
<td>Not in the worst 5% of units</td>
<td>✗</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Non-clinical transfers**

The service moved patients only when there was a clear medical reason or in their best interest.

**Pilgrim Hospital**

For the critical care unit at Pilgrim Hospital, 0.7% of admissions had a non-clinical transfer out of the unit. This was within expected range.

**Metrics (Audit measures)**

<table>
<thead>
<tr>
<th></th>
<th>Trust performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crude non clinical transfers</strong> <em>(Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)</em></td>
<td>0.7%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

The ICNARC data for high risk sepsis admissions for the ward was higher than expected for April to June 2018 at 31.3%. This figure had dropped significantly during July to September 2018 to 16.7%. Managers told us the trust had done a lot of work around sepsis management with the wards which they believed had meant the rate of admissions to critical care had reduced.

Managers monitored that patient moves between wards were kept to a minimum. Staff tried to prevent transfer from critical care areas to the general ward between 10pm and 7am. Where this did happen, staff reported this on their incident reporting system. Managers reviewed each case to see what the issue was to try and reduce the occurrence.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff completed discharge plans for patients during their stay. A patient told us staff had discussed their discharge plan with them.
Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff received support from the hospital crisis team and the safeguarding team to ensure appropriate discharge of patients with additional needs.

Managers monitored the number of delayed discharges and took action to prevent them. Managers told us where there were delayed discharges of more than four hours, this was mainly due to beds not being available on wards. There were 19 delayed discharges in April 2019 and 17 in May 2019. The service had put into place and action plan since the last inspection. The service were working with medical teams to agree a better way of working to reduce the delay in transfer of patients to the care of a medical ward.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints

The service clearly displayed information about how to raise a concern in patient areas. The unit had a display board providing patients and visitors information on how to submit comments about the service. The hospital had a patient advice and liaison service which was clearly visible to make it easier for patients and their families to make complaints about the service.

Trust level

From March 2018 to February 2019 the trust received three complaints in relation to critical care (0.4% of total complaints received by the trust).

The trust took an average of 44 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 35 working days, or 50 working days for more complex complaints. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Care &amp; treatment</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Values and behaviour</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Both Lincoln County hospital and Pilgrim hospital had one complaint each, with the third relating to Grantham hospital.

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

Number of compliments made to the trust

From March 2018 to February 2019, there were 398 compliments about critical care at the trust. A breakdown of compliments by site is below

<table>
<thead>
<tr>
<th>Site name</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of compliments</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>290</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>108</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>398</strong></td>
</tr>
</tbody>
</table>

Both sites just had the one department which received compliments. These are detailed above.
The trust noted that, alongside the compliments received by wards and services, there were an additional 746 comments recorded trust-wide. These were comments from patients, families and staff directly to the services and staff with whom they came in contact.

A theme from the compliments received trust-wide was good communication.

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

Ward managers investigated complaints and identified themes. Patients received feedback from managers after the investigation into their complaint. The ward manager told us complaints were investigated by a ward manager, supported by consultants where needed. The ward manager kept patients and families informed of progress with their complaint and gave feedback following the outcome of the investigation.

Managers shared feedback from complaints and concerns with staff and learning was used to improve the service. Comments were reviewed by the matron and ward managers and themes were shared with staff and with colleagues at the monthly clinical governance meetings. Staff were aware that the number of complaints about the service was low. The ward manager investigated complaints and provided a timely response to the complainant with an apology and findings from the investigation. The complaint was handled in a way which ensured openness and transparency, whilst respecting patient confidentiality.

**Is the service well-led?**

**Leadership**

**Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**

The trust had a new Trust Operating Model, which meant leadership for the critical care unit was under the divisional leads for surgery including the divisional clinical director, divisional managing director and the divisional nurse. The service was overseen by the Theatres and Critical Care (TACC) team which included the lead nurse, clinical service manager and the clinical lead for critical care. The matron led the service at a local level across sites.

The critical care unit at Pilgrim Hospital was led by specialism consultants and ward managers. The range of experience within the senior team enabled effective leadership of the critical care service.

The divisional leads were newly appointed in post and were still getting to know the units and staff. Staff we spoke with were not aware of who the new leadership team were, although most were aware there had been changes to senior managers.

We found the matron; lead consultants and ward managers had a good oversight of the service and understood the challenges to quality and sustainability and they identified actions needed to address them. We spoke with the matron about challenges such as the service’s winter pressures planning. Managers had plans to manage at times when capacity might increase suddenly.

Staff told us they felt managers were visible and approachable and they received appropriate support to allow them to complete their jobs effectively.

There was a lead consultant and ward manager every day for each unit. A matron had oversight of the three units and was not delivering patient care. There was ward manager or sister cover for both units 24 hours a day, seven days a week.
The matron told us of the service planned to rotate nursing staff across to the Lincoln site and rotate the staff at Pilgrim Hospital to the Lincoln site. The matron stated this was a good career progression for staff and a positive opportunity for cross site teamwork. A positive response had been received from staff.

Referrals were made to the trust’s mental health liaison service to ensure further support was provided for patients with mental health conditions.

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients and relatives.

The trust had values of being patient-centred, safety, excellence, compassion and respect. We observed all staff in critical care followed these values.

The trust vision and strategy were inclusive of people with mental health conditions.

The critical care service had its own vision for critical care delivery which was displayed in the staff room. This was to deliver appropriate evidence-based care, facilitate timely admissions, effective critical care provision, timely and appropriate discharges and information sharing between the multidisciplinary teams, patients and their families. Managers and staff spoke with us about these themes and were motivated to provide the best service possible.

The middle management team identified the critical care strategy was to step down patients from level one appropriately and in a timely manner, and to improve patient experience. Managers recognised this aligned to local plans in the wider health and social care economy. Managers ensured services had been planned to meet the needs of relevant population.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff of all levels and roles said the service was a good place to work with no bullying or culture issues. A nurse told us staff could admit mistakes and the culture was not punitive but was a learning culture.

Staff felt well supported by managers as the role in critical care by its nature was emotionally challenging for staff. Managers showed an awareness of how difficult the role was and made allowances for staff to take time out and have debriefings to support them with emotional stress.

Staff said that consultants and junior doctors were friendly and supportive and would answer any questions they had. Staff said the managers genuinely cared about staff and they really felt like part of the team.

Staff in the critical care outreach team felt valued and supported when working on wards across the hospital.

The unit demonstrated effective multidisciplinary working, across all levels there was a clear mutual respect. Nursing and medical staff had positive and supportive relationships and would share learning across the disciplines to work collaboratively, share responsibility and to resolved conflict quickly and constructively.

**Governance**
The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The unit had a newly appointed senior management team. At the time of our inspection they did not appear to have a clear oversight of the governance on the critical care unit. However, the local managers had sound knowledge of governance processes.

Managers attended monthly multidisciplinary clinical governance meetings to discuss incidents, safety thermometer and audits. The service had a robust system in place for reporting, investigating, and learning from all patient safety incidents, in line with guidelines for the provision of Intensive Care Services.

There was a sepsis lead nurse who provided updates for the unit and staff could ask for advice. The risk and governance lead consultant held monthly morbidity and mortality meetings where all deaths were discussed. The lead consultant explained they liaised with partner specialisms to talk about how to improve processes following death reviews.

The service had monthly trust wide critical care delivery group meetings. This meant that staff across hospital sites could discuss topics such as audits, incidents, staffing and training. Staff also heard reports from the physiotherapy service, pharmacy service and dietetics service.

Pilgrim Hospital critical care team was part of the Mid Trent critical care network and was active in the development of guidelines for critical care. The Mid Trent network fed into the national critical care network, ensuring the service was always up to date with current critical care best practice.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service had plans in place in case of fluctuations in demand. We spoke with the matron about potential increases in demand. The service had three additional equipped rooms above the nine beds in case of greater demand. The service had plans in place for business continuity if the clinical information system (CIS) was unavailable.

There was corporate electronic risk register in place for recording and managing risks. The risk register included a description of each risk, the owner and actions taken. Managers explained the challenges for the service and showed us the trust risk register displaying the risks. We saw the current risks were delayed discharges and pharmacy cover.

Managers attended monthly clinical governance meetings to discuss incidents, safety thermometer and audits. Ward managers and sisters held monthly critical care meetings to look at staffing, finances, admissions, equipment issues and safety thermometer results. Ward managers escalated any concerns to the monthly clinical governance meeting.

Consultants and staff led on internal audits such as a volume being ventilated, sedation hold, pressure ulcers and nursing health record keeping.

The governance leads, and consultants made any changes to local guidance following the audits and checked staff were clear about how to implement changes.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
Staff used an electronic clinical information system (CIS) for patients which had password security. Staff used some paper records, such as discharge information for wards.

Service performance measures were reported and monitored. The matrons and ward managers had access to a quality and safety figures, which provided performance measures.

Risk and governance staff recorded discussions about incidents, the risk log, information governance, harm events and audit results at monthly clinical governance meetings.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Staff knew the executive team and said the chief executive stayed in touch with staff by sending a regular blog to staff by email. Staff said they received regular updates on developments across the trust through email and social media.

Staff said ward managers sent out regular emails to staff with updates about the service. Managers had acted on staff feedback by displaying reported incidents and action taken in the staff room.

Managers prioritised the participation and involvement of people who use services and staff. Managers managed complaints effectively, appropriately investigated them and provided timely feedback.

People who used services, those close to them and their representatives were actively engaged and involved in decision-making, as the service held patient experience events annually, to allow people who previously used the service and those close to them to give feedback in ways to make the service better for patient care.

The unit also offered a follow up clinics for patients who had been on a ventilator for more than 72 hours and had been home for three months.

The service encouraged patients and relatives to provide feedback. The unit had a display board providing patients and visitors information on how to submit comments about the service.

Relatives were heavily involved in decisions about their family members care and their welfare was also considered by staff. Staff spent time with patients and family members to support them with their emotional wellbeing.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The service had several audits and action plans which took information about performance and looked at ways the service could make improvements. The service had considered changes to procedures, training and working collaboratively with internal and external partners for the benefit of the patients and their families.

Leaders of the critical care service promoted staff to lead on innovative projects to promote improvement to the service to benefit patients and their families.

There had been some incidents of pressure ulcers following patients requiring a tracheostomy tube. Staff had put into place a suture removal laminated card to be placed next to patients’ beds.
This was to remind staff when the suture needed to be removed to prevent pressure ulcers due to sutures being in place longer than necessary.

The service improvement lead, with support from staff had carried out a patient sleep audit. Staff monitored how much sleep patients had. The service improvement lead explained that patients sleep was interrupted by the normal noises and lights in the unit. The service introduced sleep packs for patients containing ear plugs and an eye mask to try and help them to sleep. Staff said patients had given positive feedback about the packs.

Staff had developed a new leaflet to provide information for patients about their rehabilitation they left the critical care unit and were moved to a ward. The leaflet prompted staff to pass on information to staff on the receiving ward, including doctors. This was in response to an audit showing staff did not always record hand over to doctors on the wards. Staff explained they were planning to monitor the success of the leaflet.
Maternity services provided by United Lincolnshire Hospitals NHS Trust is located on three hospital sites: Lincoln County Hospital, Pilgrim Hospital and Grantham and District Hospital. In-patient services are delivered at both Lincoln and Pilgrim hospitals whilst outpatient services are provided at Grantham and District Hospital.

Services on all sites are run by one maternity and gynaecology management team.

(Source: Routine Provider Information Request (RPIR) – Acute sites)

From January 2018 to December 2018 there were 4,702 deliveries at the trust.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at United Lincolnshire Hospitals NHS Trust – Comparison with other trusts in England.

A profile of all deliveries and gestation periods from January to December 2018 can be seen in the tables below. The trust had an older age profile when compared to the England averages.
### Profile of all deliveries (January to December 2018)

<table>
<thead>
<tr>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
</tbody>
</table>

#### Single or multiple births

<table>
<thead>
<tr>
<th></th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single</td>
<td>4,635</td>
<td>98.7%</td>
</tr>
<tr>
<td>Multiple</td>
<td>63</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

#### Mother’s age

<table>
<thead>
<tr>
<th></th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 20</td>
<td>204</td>
<td>4.3%</td>
</tr>
<tr>
<td>20-34</td>
<td>3,759</td>
<td>80.0%</td>
</tr>
<tr>
<td>35-39</td>
<td>609</td>
<td>13.0%</td>
</tr>
<tr>
<td>40+</td>
<td>126</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

#### Total number of deliveries

<table>
<thead>
<tr>
<th></th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total</td>
<td>4,698</td>
<td></td>
</tr>
</tbody>
</table>

*Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.

### Gestation periods (January to December 2018)

<table>
<thead>
<tr>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
</tbody>
</table>

#### Gestation period

<table>
<thead>
<tr>
<th></th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>3,810</td>
<td>92.8%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

#### Total number of deliveries with a valid gestation period recorded

<table>
<thead>
<tr>
<th></th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total</td>
<td>4,107</td>
<td></td>
</tr>
</tbody>
</table>

*Notes: This table does not include deliveries where the delivery method is ‘other’ or ‘unrecorded’. Gestation periods were unrecorded for 12.6% of deliveries at this trust compared to 18.7% nationally.

To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with ‘*’ (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, additional numbers (generally the next smallest) have also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter from October 2016 to December 2018 can be seen in the graph below.

**Number of deliveries at United Lincolnshire Hospitals NHS Trust by quarter.**
Maternity services at Pilgrim Hospital included an antenatal clinic, an antenatal assessment unit, and a maternity ward (M1) consisting of 15 beds. The labour ward has eight rooms, one of which includes a birthing pool and two theatres.

Trust wide community midwife teams covered Skegness, Spalding, Grantham, Sleaford, Lincoln, Gainsborough and Boston.

The Early Pregnancy Assessment Unit (EPAU) was located within the gynaecology unit. The EPAU provided early scans and consultations for women experiencing problems in pregnancy between six and 20 weeks gestation.

There were 1585 births at Pilgrims Hospital between July 2018 and May 2019.

During our inspection, we visited all clinical areas and departments relevant to the service. We spoke to 21 members of staff including senior managers, service leads, midwives, maternity support workers, domestic staff, obstetricians, junior doctors and a student nurse. We spoke with 11 women and six family members. We observed care and treatment and reviewed 13 sets of medical records.
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 service provided mandatory training in key skills to all staff and monitored training records to make sure everyone completed it.

The trust set a target of 90% for completion of mandatory training, with the exceptions of:
- Fraud awareness and infection prevention level one, which had targets of 95%.
- Local fire procedures and fire safety, which had targets of 100%.
- Immediate life support (ILS)/advanced life support (ALS) and medicine management training which had no targets. The trust informed us that the eligible numbers of staff were not available for these two courses and therefore we were unable to calculate completion rates.

The trust’s medical staff worked across both maternity and gynaecology.

A breakdown of compliance for mandatory training courses as of February 2019 for qualified nursing staff in maternity at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>85</td>
<td>85</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>84</td>
<td>85</td>
<td>98.8%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>84</td>
<td>85</td>
<td>98.8%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>82</td>
<td>85</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>82</td>
<td>85</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>82</td>
<td>85</td>
<td>96.5%</td>
<td>100%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>82</td>
<td>85</td>
<td>96.5%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>79</td>
<td>85</td>
<td>92.9%</td>
<td>100%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>79</td>
<td>85</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>77</td>
<td>85</td>
<td>90.6%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Basic life support</td>
<td>76</td>
<td>85</td>
<td>89.4%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicine management training</td>
<td>21</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

In maternity the target was met for six of the 11 applicable mandatory training modules for which qualified nursing staff at Pilgrim Hospital were eligible. The remaining module had no eligible staff number available and no completion target but had staff members who had completed the module.

A breakdown of compliance for mandatory training courses as of February 2019 at Pilgrim hospital for medical staff in maternity and gynaecology is seen below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>9</td>
<td>11</td>
<td>81.8%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>9</td>
<td>11</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Basic life support</td>
<td>9</td>
<td>11</td>
<td>81.8%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Across maternity and gynaecology, the target was not met for any of the 11 mandatory training modules for which medical staff were eligible. However, the completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.

In addition, staff attended yearly multidisciplinary emergency skills and drills training. This included; maternal and neonatal resuscitation, electronic fetal monitoring, management of obstetric emergencies, recognition of severely ill pregnant women, antenatal and new born screening, infant feeding, diabetes and weight management.

Clinical staff completed training on recognising and responding to women with mental health needs, learning, disabilities, autism and dementia.

Midwives also completed cardiotocograph (CTG) training and the service held weekly CTG review meetings.

A trust wide clinical education team monitored mandatory training to make sure staff were up to date with their training.

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

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

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

A breakdown of compliance for safeguarding training courses for qualified nursing staff in maternity at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>82</td>
<td>85</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>82</td>
<td>85</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 3 additional)</td>
<td>23</td>
<td>24</td>
<td>95.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>79</td>
<td>85</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>79</td>
<td>85</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>79</td>
<td>85</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for each of the six safeguarding training modules for which qualified nursing staff in maternity at Pilgrim Hospital were eligible.

A breakdown of compliance for safeguarding training courses as of February 2019 at Pilgrim Hospital for medical staff in maternity and gynaecology is shown below:
### Training module name

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>10</td>
</tr>
</tbody>
</table>

Across maternity and gynaecology, the 90% target was met for each of the six safeguarding training modules for which medical staff were eligible.

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

The maternity service had three dedicated safeguarding midwives. Staff made use of protection plans and safeguarding processes to ensure mothers and babies were kept safe. Midwives had access to the safeguarding database, this was password protected to ensure only authorised persons could access it with permission from the safeguarding team. There were alerts on electronic systems to indicate if a baby was subject to a child protection plan.

Staff were aware of their responsibilities in relation to safeguarding vulnerable women and to protect unborn and new born babies. Staff could locate and describe the trust safeguarding policy. Staff escalated safeguarding incidents to the safeguarding team. They could also report safeguarding incidents using an electronic system.

There were arrangements to safeguard women and their children from female genital mutilation (FGM). Antenatal staff flagged women who had undergone FGM to safeguard an unborn child from the practice.

Staff spoke highly of the safeguarding team and said they were easily accessible. Staff knew how to identify “high risk patients” and said they would refer such women to the safeguarding team. They also referred them to appropriate professionals for extra support if required.

Our review of women’s records showed staff assessed women’s social circumstances and identified any safeguarding concern.

Staff informed us there was no specialist teenage pregnancy midwife even though they handled up to 30 cases of teenage pregnancies across the trust each month. They informed us they referred babies to social care services if there was a safeguarding concern regarding a teenage mother.

Although the safeguarding team indicated the trust could benefit from additional specialist midwives to support the migrant community, teenage pregnancy, substance misuse and domestic abuse, they stated they were able to manage the workload safely.

Staff were trained to identify potential sexual exploitation of children. Staff were able to provide examples of how they safeguard vulnerable women, including victims of adult trafficking. Where relevant staff referred such cases to the police, involved social services and liaised with relevant agencies to keep women and children safe.

A specialist mental health midwife liaised with the perinatal mental health team to safeguard women with mental health issues and their unborn child. Staff captured any previous history of mental health at the antenatal clinics and escalated it to the safeguarding team.
Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas of the maternity unit we inspected were visibly clean and tidy. The service had established systems for infection prevention and control, which were accessible to staff. These were based on the Department of Health’s code of practice on the prevention and control of infections and included guidance on hand hygiene and use of personal protective equipment such as gloves and aprons.

Staff used ‘I am clean’ stickers to indicate a piece of equipment was clean and ready for use.

There was easy access to personal protective equipment (PPE). Aprons and gloves were available in all areas we inspected and we observed staff using PPE as required. There was also sufficient access to handwashing facilities. The maternity unit displayed signage prompting people to wash their hands and had guidance on good hand washing practice.

Staff were ‘bare below the elbow’ and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces and wearing PPE when caring for patients.

Where women had a known or suspected infection, they were nursed in single side rooms.

There were housekeeping staff for cleaning wards and cleaning staff understood cleaning frequency and standards. Staff signed cleaning schedules to confirm a particular area had been cleaned.

Waste management, including those for contaminated and hazardous waste were in line with national standards. Needle sharp bins were available on the unit. Sharp bins were correctly labelled and none were filled above the maximum fill line.

The service carried out hand hygiene audits every month. A breakdown of hand hygiene audits for maternity wards is shown below:

<table>
<thead>
<tr>
<th>Month</th>
<th>July 2018</th>
<th>August</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan 2019</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Antenatal clinic</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
<td>95%</td>
<td>93%</td>
<td>100%</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Labour ward</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100% hand hygiene (x1 MRSA colonisation)</td>
<td>88%</td>
<td>85%</td>
<td>83%</td>
<td>77%</td>
<td>67%</td>
<td>87%</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>M1</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>75%</td>
<td>93% hand hygiene (x1 MRSA colonisation)</td>
<td>75%</td>
<td>77%</td>
<td>67%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hand hygiene audit results showed an average compliance rate of 98% for the antenatal clinic during the period from July 2018 to May 2019. However, compliance rate for the labour and maternity ward were lower at 88% and 89% respectively.

A piece of work was undertaken by the trust between January and March 2019 (quarter four) which changed the way in which hand hygiene was assessed. Prior to this the trust would receive consistent 100% hand hygiene compliance in most areas and recognised that this probably did not reflect actual practice. The trust therefore changed the hand hygiene assessment methodology to...
better reflect a more accurate position and to show the areas where non-compliance needed support. During quarter four, the infection prevention and control (IPC) team briefed the trust IPC committee to advise that they expected hand hygiene numbers to decline as the new assessment tool was rolled out. This guided the IPC team on where they needed to focus their efforts to support improvements.

There had been two incidents of Methicillin-resistant Staphylococcus aureus (MRSA) colonisation during the period.

Data received from the trust showed 83 babies were admitted due to infections between 1 June 2018 and 31 May 2019.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Access to and exit from inpatient areas were secure and restricted to staff with swipe cards. Visitors entering the unit used a call bell to alert staff of their presence and staff escorted visitors to exit the unit. Staff assisted visitors to exit the unit using swipe cards. CCTV cameras were in use to identify visitors entering the labour ward. However, the CCTV camera did not cover the exit from the labour ward. This was on the divisional risk register and we noted staff physically identified people leaving the labour ward before opening the door for people leaving the labour ward. The trust had an abduction policy which instructs staff on how to respond in the event of child abduction.

The maternity unit consisted of an antenatal outpatient area, a labour ward and a new M1 maternity ward. The maternity unit was well laid out for the provision of care. Theatres used by the maternity service were also fit for purpose, clean and ventilated. Staff had easy access to emergency obstetric theatres located adjacent to the labour ward. The neonatal unit was also near the labour ward. Elective caesarean sessions were carried out in the main theatres which was a floor above the labour ward. Staff could move patients to the main theatres via a lift.

There were appropriate emergency equipment on the maternity unit. We saw the resuscitation trolleys were fully equipped, with drugs in date, and staff checks were signed and dated. Staff checks were also completed for each resuscitare (a warming platform used for clinical emergencies and resuscitation).

We noted trolleys and equipment were stored in a parallel corridor adjacent to the labour ward. This did not appear to compromise access.

All equipment we looked at across the unit had been routinely checked for safety with visible safety stickers demonstrating when the equipment was next due for service. This included infusion pumps. Blood pressure and cardiac monitors as well as baby scales. Cardiotocography (CTG) equipment had been checked and labelled with the due date of the next maintenance check. CTG equipment is used to monitor a baby’s heart rate and a mother’s contractions while the baby is in the uterus. Staff were aware of the process of reporting faulty equipment.

Clinical waste disposal was in line with national standards. Staff used colour coded bags and bins to segregate clinical waste from non-clinical wastes. Clinical waste was appropriately stored in a secure room with swipe access and disposed of.

**Assessing and responding to patient risk**
Staff completed and updated risk assessments for each patient and took action to removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Maternity staff used the Modified Early Obstetric Warning Score (MEOWS) to recognise women who were becoming unwell. We checked 10 sets of inpatient records and found these had been completed and scores were calculated. Staff informed us they had good access to critical care teams when they had concerns around a woman’s deteriorating health.

Staff had received training to complete new born baby checks within 72 hours of birth and staff recorded their assessment of new born babies all records we reviewed.

Staff carried out risk assessments for women during antenatal care in line with national guidance. These included social assessment, Venous thromboembolism (VTE) risk assessment and mental health assessment. Social assessments included an assessment of emotional well-being. This was used to classify whether women were low or high risk. Low risk women continued with midwifery led care, whilst high risk women received consultant led care. Staff recorded relevant information during initial booking appointments including information about previous births and early pregnancy losses, tobacco use and drug use.

There were arrangements to ensure that checks were made prior to, during and after surgical procedures in accordance with best practice. This included completion of an adaptation of the World Health Organisation (WHO) surgical safety checklist. The service completed monthly audits of the WHO checklist. We reviewed data from January 2019 to May 2019 which showed staff had completed all sections of the checklist for each of the patient reviewed.

Midwives had access to consultants for difficult deliveries including caesarean sections.

Staff assessed patients upon admission to the antenatal service to identify women who had extra needs.

A multidisciplinary handover took place on labour ward twice a day, following a situation background, assessment, recommendation (SBAR) format. Staff from all areas attended this and discussed the sickest patients and areas of concern around the unit.

There was a clear criteria for women wishing to have a home birth or a pool birth. This was in line with national guidance requiring such women to be fit and healthy and experiencing a normal pregnancy. Midwives undertook an environmental risk assessment of the home and birth space, lighting and equipment in the home. Women giving birth at home or in a birth centre were transferred to the labour ward if midwives had concerns about foetal heart rate anomalies or failure for labour to progress.

Community midwives referred women who they identified as high risk for any medical reason to consultant-led clinics.

Senior staff informed us one of the risks for the maternity unit was the lack of an emergency buzzer system on labour ward. To mitigate this risk, staff used a draw string call bell which they pulled trice to alert other staff about an emergency during labour. Staff said they regularly informed locum and new doctors that a call bell was in use for this purpose.

**Midwifery and nurse staffing**

The service had enough maternity staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave
bank staff a full induction.

Pilgrim Hospital reported the following WTE the nurse and midwifery staff numbers for the periods below for maternity.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Midwifery rotational</td>
<td>18.8</td>
<td>16.9</td>
</tr>
<tr>
<td>Community midwifery</td>
<td>17.3</td>
<td>19.3</td>
</tr>
<tr>
<td>Labour Ward</td>
<td>18.4</td>
<td>20.1</td>
</tr>
<tr>
<td>Antenatal clinic</td>
<td>7.5</td>
<td>9.5</td>
</tr>
<tr>
<td>Ward M1 maternity</td>
<td>8.1</td>
<td>8.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70.1</strong></td>
<td><strong>74.5</strong></td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the nurse and midwifery staffing rate within maternity at Pilgrim Hospital name was 94.0%. This was slightly lower than the rate of 97.1% from April 2018 to February 2019. Both the actual number of WTE staff in post and the number of planned WTE staff decreased in the more recent period.

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

**Vacancy rates**

From April 2018 to March 2019, the trust reported a vacancy rate of 2.9% for midwifery staff at Pilgrim Hospital. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

A breakdown of vacancy rates by ward/department for Pilgrim Hospital is below

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward M1 maternity</td>
<td>23.0%</td>
</tr>
<tr>
<td>Antenatal clinic</td>
<td>18.3%</td>
</tr>
<tr>
<td>Labour ward</td>
<td>14.0%</td>
</tr>
<tr>
<td>Community midwifery</td>
<td>0.2%</td>
</tr>
<tr>
<td>Midwifery rotational</td>
<td>-30.7%</td>
</tr>
</tbody>
</table>

The negative figure indicates there were more WTE in post than originally planned.

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

**Turnover rates**

From April 2018 to March 2019, the trust reported a turnover rate of 4.3% for midwifery staff at Pilgrim Hospital. This was lower than the trust target of 8%.

A breakdown of turnover rates by ward/department is below:

There were three wards with turnover recorded at Pilgrim from April 2018 to March 2019.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal clinic</td>
<td>12.5%</td>
</tr>
<tr>
<td>Labour Ward</td>
<td>8.5%</td>
</tr>
<tr>
<td>Midwifery rotational</td>
<td>2.6%</td>
</tr>
</tbody>
</table>
Sickness rates

From April 2018 to March 2019, the trust reported a sickness rate of 3.8% for midwifery staff at Pilgrim Hospital. This was lower than the trust target of 4.5%.

A breakdown of sickness rates by ward/department for Pilgrim Hospital is below.

**Pilgrim Hospital**

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward M1 maternity</td>
<td>11.3%</td>
</tr>
<tr>
<td>Labour Ward</td>
<td>4.5%</td>
</tr>
<tr>
<td>Antenatal clinic</td>
<td>4.3%</td>
</tr>
<tr>
<td>Midwifery rotational</td>
<td>2.5%</td>
</tr>
<tr>
<td>Community midwifery</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

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

Bank and agency staff usage

**Pilgrim Hospital**

The tables below show the numbers and percentages of nursing hours in maternity at Pilgrim Hospital from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

**Qualified nursing staff**

Of the 111,339 total working hours available, 4.0% were filled by bank staff and 0.0% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 10.1% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Midwifery</td>
<td>35,490</td>
</tr>
<tr>
<td>Ante Natal Clinic</td>
<td>19,554</td>
</tr>
<tr>
<td>Labour Ward</td>
<td>39,264</td>
</tr>
<tr>
<td>Ward M1 Maternity</td>
<td>17,031</td>
</tr>
<tr>
<td>Total</td>
<td>111,399</td>
</tr>
</tbody>
</table>

**Non-qualified nursing staff**

Of the 32,534 total working hours available, 27.1% were filled by bank staff and 0.0% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 32.5% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Site name</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Community Midwifery</td>
<td>2,933</td>
<td>8</td>
<td>0.3%</td>
<td>0</td>
</tr>
<tr>
<td>Ante Natal Clinic</td>
<td>5,866</td>
<td>1,237</td>
<td>21.1%</td>
<td>0</td>
</tr>
<tr>
<td>Labour Ward</td>
<td>10,771</td>
<td>1,347</td>
<td>12.5%</td>
<td>0</td>
</tr>
<tr>
<td>Ward M1 Maternity</td>
<td>12,964</td>
<td>6,229</td>
<td>48.0%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>32,534</td>
<td>8,821</td>
<td>27.1%</td>
<td>0</td>
</tr>
</tbody>
</table>

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

There were sufficient staffing levels during our inspection. The postnatal and antenatal inpatient unit were staffed by three midwives and two midwifery support workers. In addition, there were five midwives and one support worker on the labour ward.

Staffing levels were displayed in all the clinical areas we visited and we saw information displayed indicated actual staffing levels met planned staffing levels.

The service used the National BirthRate Plus acuity tool to calculate midwifery staffing levels. Between December 2018 and May 2019, there were 243 occasions when the labour ward coordinator was not supernumerary equating to 22% of the time. There were peaks in January and February 2019 which related to high sickness rates across the labour ward and maternity ward.

The service utilised the NICE ‘red flag’ system that alerted when patient safety was compromised due to staffing issues for example delay in suturing or not achieving one to one care in labour. Between December 2018 and May 2019, there were seven red flags (0.64% of shifts) recorded at the maternity unit. During the same period there were four occasions (0.4% of shifts) where women were not offered one to one care in labour.

Senior staff informed us there were 3.4 WTE midwifery vacancies at the time of our inspection. The service was actively recruiting for these positions and had shortlisted candidates for interviews.

The ratio recommended by ‘Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour’ (Royal College of Midwives 2007), based on the expected national birth rate, was one whole time equivalent (WTE) midwife to 28 births. Pilgrim Hospital maternity midwife to birth ratio was in line than the recommended standard.

(Source: DR133)

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The trust’s medical staff work across both maternity and gynaecology.

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for maternity and gynaecology.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
</tbody>
</table>
Vacancy rates

Trust level

From April 2018 to March 2019, the trust reported a vacancy rate of 5.6% for medical staff in maternity and gynaecology. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Pilgrim Hospital maternity department: -0.4%

The negative figure indicates that there were more WTE in position than originally planned.

Turnover rates

From April 2018 to March 2019, the trust reported a turnover rate of 22.6% for medical staff in maternity and gynaecology. This was higher than the trust target of 8.0%. Turnover data for medical staff includes trainee grades which may have inflated the rate.

- Pilgrim Hospital maternity department: 20.7%

Sickness rates

Trust level

From April 2018 to March 2019, the trust reported a sickness rate of 6.4% for medical staff in maternity and gynaecology. This was higher than the trust target of 4.5%.

- Pilgrim Hospital maternity department: 9.5%

Bank and locum staff usage

Please note that the trust confirmed that they were unable to provide accurate establishment hours by department and location in all cases. Therefore, we have not calculated the proportion of hours filled by bank and locum staff or left unfilled as this may be misleading.

The table below shows the number of medical hours in maternity and gynaecology at Pilgrim Hospital from April 2018 to March 2019 that were covered by bank and locum staff or left unfilled.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank usage</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>1,749</td>
</tr>
</tbody>
</table>

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

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

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

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Staffing skill mix

In January 2019, the proportions of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust were lower than the England averages.

Staffing skill mix for the 45.6 whole time equivalent staff working in maternity at United Lincolnshire Hospitals NHS Trust.

<table>
<thead>
<tr>
<th>Staffing Level</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>32%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>59%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>4%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

Obstetric consultant cover was 52 hours a week shared between eight consultants. The Royal College of Obstetricians and Gynaecologist (RCOG) 2007 guidelines states that for a unit with less than 2500 deliveries a year, the unit must continually review staffing to ensure adequate cover based on local needs. Staff informed us staffing was regularly reviewed and we saw this in minutes of meetings held within the division.

Staff informed us they were happy with medical staffing including overnight medical staffing. They informed us they always had registrar and Senior House Officer (SHO) cover at night. Consultant presence on the unit was from 9am to 5pm Monday to Saturday and in the morning on Sunday. Staff also had access to a consultant on call, located within 30 minutes travel time to the hospital.

Dedicated anaesthetic cover was provided twenty four hours a day with an on call anaesthetist available to cover women who needed to go to theatre.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women’s care were recorded using paper format (for intrapartum care) and the electronic maternity system. Staff stored paper records securely in restricted areas or lockable trolleys within clinical areas in line with data protection policies. Electronic systems were password protected and we observed staff signing out of systems once they completed their tasks.
All women attending antenatal clinics carried their own pregnancy-related care notes and brought them when they came to the hospital. The hospital also held medical records relating to each woman.

We looked at 13 sets of records across the inpatient wards and antenatal clinic. Records were legible, dated and signed. The records were comprehensive with all appropriate risk assessments completed. Staff completed checklists including VTE risk assessments, partogram (a composite graphical record of key maternal and foetal data during labour), WHO checklist, charts for growth and early warning scores. Staff also recorded details of previous births and early pregnancy losses, social assessments, mental health assessments, tobacco and drug use, and pain assessments.

Child health records known as ‘red books’ were given to mothers for each new born baby following the completion of new-born and infant physical examinations.

All ward staff completed a SBAR form (situation, background, assessment, recommendation) to handover information. This ensured information given was clear, concise and relevant.

Postnatal notes included risk assessments for the community midwives and gave concise information about the pregnancy.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Medicines were stored safely and securely. All drug storage cupboards were securely locked and regular audits were completed regarding the accuracy of controlled drug documentation. Medicines requiring cold storage were stored in dedicated fridges.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Women were able to self-administer medications following assessment in line with trust policy. The use of over-labelled packs for discharge had reduced delays in obtaining medicines for patients to take home. However, we were told that delays still occurred as medicines charts had to leave the ward for dispensing of any medicines not held.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. Midwives and the breast feeding advisor counselled women about their medicines.

Staff followed current national practice to check patients had the correct medicines. Pharmacy staff attended the ward daily and documented review of patients’ medicines in medication charts.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Whilst staff were aware of safety alerts and recalls, we did not see an effective feedback mechanism to ensure the trust was assured appropriate actions had been taken. Good examples of shared learning across the sites was evidenced.

**Incidents**

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
Never events

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

From March 2018 to February 2019, the trust reported no never events for maternity.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, Pilgrim Hospital reported five serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from March 2018 to February 2019.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident: mother and baby (this include foetus, neonate and infant)</td>
<td>2</td>
<td>40.0%</td>
</tr>
<tr>
<td>Maternity/Obstetric incident: baby only (this include foetus, neonate and infant)</td>
<td>2</td>
<td>40.0%</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff reported 612 incidents at Pilgrim Hospital between July 2018 and June 2019. Of these, 545 incidents were classified as “no harm”, 62 as “low harm”, four as “moderate harm”, one as “severe harm”.

We reviewed three investigation reports and found appropriate investigations had taken place. We found the trust had identified the root causes, analysed the contributing factors to the incident and identified actions to reduce the risk of similar incidents occurring in the future. For example, following a still birth, recommendations were made for carbon monoxide monitoring to be offered at every appointment for women who had smoked cigarettes in pregnancy in accordance with trust policy.

Staff at all levels were able to tell us how to report an incident and told us they received feedback both on individual incidents they reported and on incidents that affected their unit. Senior staff debriefed or supported staff involved in SIs.

Staff reviewed incidents at speciality governance meetings, monthly matrons meetings and at staff meetings. Learnings from incidents were shared during handovers, team meetings, on staff notice boards and newsletters.

Staff understood their responsibility under the duty of candour regulations and we saw examples of the correct process being followed from our review of RCA reports.

A perinatal and maternal mortality and morbidity presentation was held monthly and involved multidisciplinary team members (MDT). All cases presented by the medical staff had been through the risk management process. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared
learning. We reviewed presentations from the last three meetings and saw staff reviewed cases in detail with areas of good practice highlighted, together with learning outcomes.

**Safety thermometer**

**The service used monitoring results well to improve safety.** Staff collected safety information and shared it with staff, patients and visitors.

The maternity safety thermometer is a measurement tool for improvement that focuses on: blood loss over 500ml, perineal tears (tears to the area between the vagina and rectum during birth), maternal infection, the psychological well-being of the mother and the baby’s health scores in the first 10 minutes after birth.

Staff completed a modified dashboard of information stating the percentages of events, including the maternity safety thermometer events. The Pilgrim Hospital maternity dashboard covered the period from April 2018 to March 2019. It showed the proportion of women having blood loss over 1500mls was red rated at 4.59% against the target of 2.7% or less.

Total postpartum haemorrhage over 1000ml was 11.53% against a target of 14.5%. The service achieved a green rating for the overall proportion of women who sustained a third or fourth degree tear for spontaneous delivery (3.19%) against a target of 3.5%.

During the same period, the number of admissions to neonatal unit was 105. Also included were babies having an apgar score of less than seven at five minutes. This was green rated at 0.63% against a target of 1.2% or less.

We saw that senior staff reviewed performance measures during governance meetings as well as other unit meetings and made recommendations for improvement. For example, the combined speciality governance and business report for May 2019 indicated a risk assessment tool was being developed to identify women with risk factors for PPH.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice in most cases. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

There were clear policies and procedures in line with best practice guidelines. These included National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). This included the ‘Safer childbirth: minimum standards for the organisation and delivery of care in labour’. These standards set out guidance about the organisation, safe staffing levels, staff roles, education, training and professional development.

Staff had access to guidelines on the trust's intranet system. We reviewed a sample of guidelines and found they were up to date.

Sepsis screening and management was in line with national guidance. The use of the sepsis screening tool was embedded on the unit. There were prompts visible around the unit encouraging staff to “think sepsis” in relation to a range of symptoms.

Women with risk factors for gestational diabetes were identified and offered glucose tolerance testing in line with current NICE guidelines.

The unit took part in national maternity audits such as the Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK).
The trust had implemented the Saving Babies Lives Care Bundle. These are guidelines introduced to reduce stillbirth rates in the United Kingdom. Senior staff informed us they were in the process of implementing Saving Babies Lives Version Two Care Bundle to reflect the updated government ambition to reduce the number of babies who are born preterm.

The unit had implemented the GROW (Gestation Related Optimal Weight) charts, customised antenatal charts for plotting fundal height and estimated foetal weight as part of the co-ordinated growth assessment programme (GAP). This is an evidence based programme which supports the detection of small for gestational age (SGA) babies. Where SGA babies were identified during the antenatal period, women involved would be recommended to receive a growth scan and if necessary, an obstetric review.

Staff in the antenatal clinic identified scanning capacity as one of the risks on the maternity unit. The risk register indicated the trust was only able to offer scans on four weekly basis to women identified as high risk for SGA or fetal growth restriction (FGR). The trust was unable to offer routine scanning to women with BMI of 35 – 39.99. This was not in line with GAP and GROW guidance which states all women identified as high risk for SGA/FGR should be scanned every three weeks. This included women with a BMI that was greater than 35. The risk register indicated community midwives were seeing women every three weeks to conduct fundal height measurement.

An audit programme was in place for a range of service wide audits. During the last inspection, we found that many of the audits did not possess timelines including presentation dates. The local audit programme provided following our recent inspection included timelines, planned presentation dates, audit status and completion date.

Audits were carried out to improve local practice. For example, following the introduction of new hypoglycaemia guidelines in February 2018, there had been an 87.5% reduction in admissions with hypoglycaemia as the principle diagnosis.

Staff protected the rights of women subject to Mental Health Act 1983 and followed the trust’s policy. Staff were aware of the requirements of the Mental Health Act and their responsibilities. Staff completed psychological and emotional assessments in women’s notes and referred them to the mental health team when required.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

The maternity unit had the United Nations Children's Fund (UNICEF) baby friendly initiative Level one accreditation for supporting new mothers with the feeding of new-borns (an international initiative to encourage breast feeding).

Breastfeeding specialist midwives and maternity support workers helped support new mothers with breastfeeding. Staff had received training to support new mothers with breast feeding. Ward staff carried out a structured assessment of breast feeding before mothers and babies went home to ensure that feeding was well-established. Women received a guide to feeding and caring for their baby as part of their antenatal information and midwives gave new mothers further guidance before discharge from the postnatal ward.

The average breastfeeding initiation rate between April 2018 and March 2019 was 64.61%. This was lower than the trust target of 73.6% and above.
Women informed us they were offered beverages and food. Food menus offered a range of options in line with cultural and dietary needs.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

We observed effective pain management for women on the ward. Women told us they received pain relief when required and this was reviewed regularly.

Detailed information regarding available pain relief options available was provided to women in the antenatal period.

We reviewed patient’s records and this demonstrated a continuous assessment of women’s pain relief options in labour.

Women’s options for pain relief included epidural analgesia and other options such as Nitrous oxide (pain relieving gas). The labour ward had a birthing pool for women to use as pain relief during labour.

Data received from the trust indicated the average mean time from women requesting an epidural to when they received one was 20 minutes.

*(Source: DR118)*

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements in most cases. However, the service achieved mixed outcomes for patients.

The unit collected data on standard maternity outcomes in line with the RCOG good practice guideline No 7 (Maternity Dashboard: Clinical Performance and Governance Score Card). At the last inspection, the trust did not set local goals for each of the parameters monitored. During this inspection, we found the trust had set local goals for parameters monitored. Data were rated red, amber or green (RAG). This meant staff could assess the data against trust targets.

We reviewed the maternity dashboard for Pilgrim Hospital for the period between April 2018 and March 2019. It showed the proportion of women having spontaneous vaginal deliveries was 64.9% which was better than the target of 62.3%. The proportion of women having instrumental deliveries (11.34%) was better than the target of 12.6%. The proportion of women having caesarean delivery (23.95%) was also better than the target of 27.8% or less.

The proportion of women having induction of labour (38.60%) was rated red and higher than the target of 28.5%. Senior staff explained they had implemented the Saving Babies Lives Care Bundle to help to reduce the rate of stillbirths. However, this also had the effect of increasing the induction rate.

The proportion of women having blood loss (greater than 1500mls) was also very high (4.59%) against a target of 2.7% or less.

The overall proportion of women who sustain third and fourth degree tears (3.19%) was less than the target of 3.5%.

**National Neonatal Audit Programme**

**Pilgrim Hospital**
The table below summarises Pilgrim Hospital’s performance in the 2018 National Neonatal Audit Programme (NNAP) against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids? (Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity)</td>
<td>89.1%</td>
<td>Within expected range</td>
<td>✓</td>
</tr>
<tr>
<td>Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?* (Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy)</td>
<td>Suppressed due to low numbers</td>
<td>n/a</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Neonatal Audit Programme)

* The maternity unit at Pilgrim Hospital delivered babies above 34 weeks gestation.

The trust completed an action plan listing action required following the NNAP audit programme. This included sharing data with the wider team and improving case note documentation. However, the action plan did not identify a lead for each action required or a completion date.

National Maternity and Perinatal Audit Programme

Pilgrim Hospital

Pilgrim Hospital submitted data to the 2017 National Maternity and Perinatal Audit Programme. However, the hospital did not pass the audit’s data quality checks to produce the metrics.

(Source: National Maternity and Perinatal Audit Programme)

Standardised Caesarean section rates and modes of delivery

From January to December 2018, the total number of caesarean sections was as expected. The standardised caesarean section rates for elective and emergency sections were also as expected.

<table>
<thead>
<tr>
<th>Standardised caesarean section rate (January to December 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of caesarean</td>
</tr>
<tr>
<td>Caesarean rate</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Elective caesareans</td>
</tr>
</tbody>
</table>
Emergency caesareans 16.5% 706 15.0% 92.9  Similar to expected
Total caesareans 29.3% 1,343 28.6% 103.0  Similar to expected

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode. This table includes all deliveries, including where the delivery method is 'other' or 'unrecorded'.

In relation to other modes of delivery, from January to December 2018, the table below shows the proportions of deliveries recorded by method in comparison to the England average. The trust had a similar profile of deliveries by recorded delivery method when compared to the England averages.

### Proportions of deliveries by recorded delivery method (January to December 2018)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections</td>
<td>1,343</td>
<td>28.6%</td>
</tr>
<tr>
<td>Instrumental deliveries</td>
<td>478</td>
<td>10.2%</td>
</tr>
<tr>
<td>Non-interventional deliveries</td>
<td>2,877</td>
<td>61.2%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>4,698</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.
1Includes elective and emergency caesareans
2Includes forceps and ventouse (vacuum) deliveries
3Includes breech and vaginal (non-assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Pilgrim Hospital maternity dashboard showed that between April 2018 and March 2019, the proportion of women having caesarean section delivery (23.95%) was green rated and better than the trust target (27.8%)

**Maternity active outlier alerts**

As of 29 April 2019, the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

**MBRRACE-UK Perinatal Mortality Surveillance Report**

The table below summarises United Lincolnshire Hospitals NHS Trust’s performance in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016:

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts with similar service provision</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilised and risk-adjusted perinatal mortality rate</td>
<td>5.0</td>
<td>Up to 10% higher than the average for the comparator group</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(The death of a baby in the time period before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK’s death rate varies across regions, even after taking into account regional differences in maternal and neonatal health. This table summarises the trust’s performance in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016.)
account differences in poverty, ethnicity and the age of the mother.)

(Source: MBRRACE-UK)

We noted the Pilgrim Hospital maternity dashboard for the period between April 2018 and March 2019 showed the still birth rate for the year average was red rated at 6.19 per 1000 births against a national rate of 4.2 per 1000 births. The rate had reduced to 5.18/1000 births by March 2019. This was still higher than the national rate.

The perinatal mortality rate for the year average was also red rated at 7.79 per 1000 births against the national rate of 5.9/1000 births. The rate had reduced to 6.33/1000 births by March 2019. This was still higher than the national rate.

The trust’s stillbirth report 2018 was completed to identify themes and trends in order to understand the rise in the stillbirth rate at the trust and to support initiatives to reduce the stillbirth rate within the maternity service. There were 11 still births at Pilgrim Hospital between January 2018 and December 2018. The report identified causes of stillbirths to include abruption, fetal abnormalities and intrauterine growth restriction. The report identified multiple risk factors which increased the risk of stillbirths for the mothers involved. These included being over 35 years old, smoking, mental illness, obesity, complex health conditions such as diabetes and living in a low socio economic area.

An action plan was created following MBRRACE-UK Perinatal Mortality Surveillance Report, which addressed the underlying causes of the higher risk adjusted perinatal mortality rate in comparison to other trusts.

The action plan included 12 recommendations. It identified action required, a lead responsible for completing the action, date to be completed and update on action.

One of the recommendations in the action plan was to reduce the number of women who smoked at the time of birth through clear referral to smoking cessation pathways as smoking was a recurrent theme. It also recommended that women should not have their ultrasound scans cancelled unless critical. Staff were to ensure that high risk women had appropriate personalised care plan.

The trust had implemented the Saving Babies Lives care bundle which was designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based practice; reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movement, effective fetal monitoring during labour.

Although some of the multiple risk factors identified in the still birth report included intrauterine growth restriction and smoking, there were insufficient measures to address these issues. The hospital’s maternity dashboard showed the percentage of women smoking at birth (20.63%) for the period between April 2018 and March 2019 was high compared with the trust’s target of less than 11.7%. In addition, the hospital had insufficient scanning capacity for women identified as high risk for SGA and FGR.

The trust was an active member of the Lincolnshire system wide smoking improvement group. There was an awareness both within the group and the trust of the smoking challenge for pregnant ladies in Lincolnshire. Significant action was being undertaken to address this challenge as part of the system group.

Competent staff
The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

A trust wide clinical education team monitored midwife competencies to make sure they were up to date with current practice based on national benchmark standards.

There were systems to ensure staff were competent to carry out their role. Newly qualified midwives had a preceptorship programme. New staff were required to complete competency-based assessments before they could work independently. They went through an orientation program designed to make them familiar with all aspects of maternity care.

A band six development programme was planned to support staff working towards their band seven position.

All Band 7 midwives had undertaken high dependency skills training. Senior staff informed us Band 6 midwives were currently undertaking the training. Data received from the trust showed 10 midwives had completed the high dependency skills training in Pilgrim Hospital.

There were specialist midwives for infant feeding, safeguarding, mental health, antenatal screening, diabetes and weight management, risk management, and bereavement as well as midwife sonographers.

Trainee doctors were satisfied with the level of support they received from obstetricians. This included regular and adhoc teaching as well as opportunities for involvement in audit. New doctors and locums went through an induction period when they joined the trust.

In addition to mandatory training maternity staff attended multi-professional obstetric training day. This included maternal and neonatal resuscitation, electronic fetal monitoring, management of obstetric emergencies, sepsis training, infant feeding and diabetes and weight management. However, the attendance rate was below the trust target of 90%. By March 2019, 76% of midwives, 78% of doctors and 100% of consultants had attended the training day.

Midwives had completed cardiotocograph (CTG) training and the service held weekly CTG review meetings. Senior staff informed us the matron, maternity ward sisters, consultants and risk midwives attended CTG review meetings. They said midwives were welcome to attend if they were free. Senior staff communicated feedback from the meeting to all staff.

Midwives had access to a Professional Midwifery Advocate (PMA). The PMA role had replaced the supervisor of midwives role. PMAs are trained support midwives in their clinical practice and advocate for women.

(Source: DR169 – HDU trained midwives)

Appraisal rates

From April 2018 to February 2019, 93.8% of required staff in maternity (and gynaecology for medical staff) at Pilgrim Hospital received an appraisal compared to the trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>9</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>77</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>19</td>
</tr>
</tbody>
</table>
Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff reported good working relations between the medical team, midwives and other staff. We observed good communication between midwives and obstetricians in delivery of care.

The maternity unit held a huddle at 9am every morning to assess workload and ensure effective communication and distribution of staff. We observed a morning huddle and it was attended by multidisciplinary team of midwives, student midwives, doctors, ward managers and consultants.

There were weekly multidisciplinary team meetings to discuss women with screening results, which may impact their pregnancy, and plans were made for delivery.

Many women had their antenatal care from midwives in GP surgeries. Midwives reported they had good working relationships with GPs and other community specialists. We saw that midwives completed the child health record (red book) to handover care to health visitors. There was a process for midwives to inform health visitors of all pregnancies and to alert them to post-natal issues including for example, signs of mental ill health at discharge.

The trust was involved in Lincolnshire’s local maternity system to deliver equitable access to maternity services in Lincolnshire.

Seven-day services

Key services were available seven days a week to support timely patient care.

Medical and midwifery staff covered all areas of the maternity service for 24 hours a day, seven days a week. Consultant obstetricians provided cover from 9am to 5pm Monday to Saturday and in the morning on Sundays. Consultants were on-call outside this hours.

The antenatal unit opened 8.30am to 6pm Monday to Friday. Routine ultrasound scan was available during working hours from Monday to Friday, and urgent ultrasound scan was available outside these hours.

Community midwives were available 24 hours a day, seven days a week to facilitate home births.

The Early Pregnancy Assessment Unit opened Monday to Friday from 7.30am to 4pm.

The antenatal assessment unit opened from 8.30am to 8pm Monday to Friday and from 8.30am to 4.30pm on weekends and bank holidays.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The trust participated in a number of initiatives to promote the health and wellbeing of women and babies.

Women were offered smoking cessation because of the impact of smoking on the baby’s growth.

The hospital’s maternity dashboard showed between April 2018 and March 2019, 54.8% of
women agreed to a referral for smoking cessation. Midwives also documented on-going risk assessments at subsequent antenatal visits.

Information about smoking cessation was displayed around clinic areas. This provided information about one to one support for women, where services were provided, stop smoking medication and contact details for the service.

Women had access to mental health provision for pregnant women and mothers, with referral to psychiatric input if needed. Women also had access to specialist clinics including diabetes and weight management.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff had access to mental health/deprivation of liberty safeguards guidelines on the trust intranet. Staff were able to talk about the deprivation of liberty safeguards (DoLS) and how this would impact a woman on the unit. Staff were aware of their responsibilities under the Mental Capacity Act.

Our review of patient notes showed that staff completed mental health assessments with prompts to identify anxiety and depression. We saw staff obtained and recorded verbal consent where appropriate, such as before a vaginal examination and written consent was recorded for procedures such as caesarean section.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The MCA training delivered covers all levels required and DoLS training is included in the same session so is not reported separately.

Please note that the trust’s medical staff work across both maternity and gynaecology.

A breakdown of compliance for MCA/DoLS training modules for qualified nursing staff in maternity at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental capacity act</td>
<td>84</td>
<td>85</td>
<td>98.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In maternity the target was met for the MCA/DoLS training module for which qualified nursing staff at Pilgrim Hospital were eligible.

A breakdown of compliance for MCA/DoLS training modules for medical staff in maternity and gynaecology at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental capacity act</td>
<td>6</td>
<td>11</td>
<td>54.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity and gynaecology, the target was not met for the MCA/DoLS training module for which medical staff at Pilgrim Hospital were eligible. However, the completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.
Is the service caring?

Compassionate care
Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We spoke with 11 women and six family members during our inspection. Feedback from women and their partners were positive. They were complementary about the antenatal and postnatal care received on the unit. Women said they were pleased with their care and described it as “fantastic care” and “excellent”. Women described staff as polite and professional. They said midwives and medical staff were friendly and caring.

All observations of care we made were positive, showing kind and compassionate care. We observed staff interactions with patients. Staff were courteous, professional and engaging. We saw staff maintaining patient privacy and dignity by drawing the curtains around patient areas before completing care tasks.

We saw many “thank you cards” from mothers displayed within the unit. Women stated, “your care and calmness helped more than you may ever know”; “each and every one of you have inspired me with the unique and amazing work you conduct each and every day; “ we have had a brilliant experience and no complaints or issues, you have been amazing”.

Staff confirmed they were satisfied with the level of care they provided to patients.

Friends and Family test performance

From March 2018 to February 2019 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally better than the England average.

In the most recent month, February 2019, 100% of mothers recommended the trust for antenatal care, compared to the England average of 95%.

Friends and family test performance (antenatal), United Lincolnshire Hospitals NHS Trust

From March 2018 to February 2019 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally better than the England average.

In the most recent month, February 2019, 98% of mothers recommended the trust for births compared to the England average of 97%.

Friends and family test performance (birth), United Lincolnshire Hospitals NHS Trust
From March 2018 to February 2019 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally better than the England average.

In the most recent month, February 2019, 95% of mothers recommended the trust for their postnatal ward which was the same as the England average.

**Friends and family test performance (postnatal ward), United Lincolnshire Hospitals NHS Trust**

From March 2018 to February 2019 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally better than the England average.

In the most recent month, February 2019, 100% of mothers recommended the trust compared to the England average of 98%.

**Friends and family test performance (postnatal community), United Lincolnshire Hospitals NHS Trust**

(Source: NHS England Friends and Family Test)

The trust’s maternity dashboard for Pilgrim Hospital showed between 97% and 100% of women indicated they would recommend the service during the period from April 2018 to March 2019.

**CQC Survey of women’s experiences of maternity services 2018**

The trust performed about the same as other trusts for each of the 18 questions in the CQC maternity survey 2018.
<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a member of staff help you within a reasonable amount of time?</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Was your discharge from hospital delayed?</td>
<td>5.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed after the birth, did a member of staff help you within a reasonable amount of time?</td>
<td>7.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.6</td>
<td>About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Women we spoke with confirmed staff explained processes in detail and were reassuring. Women using maternity services could access support for specific health related issues including diabetes or mental health needs. Midwives assessed women for anxiety and depression during their initial antenatal appointment.
Women had access to counselling services. A bereavement midwife was responsible for speaking with women who had been bereaved during or after childbirth or had a late miscarriage or termination for medical reasons. However, there was no dedicated room for bereaved women.

Trained screening midwives counselled pregnant women undergoing screening tests to check for genetic anomalies. This process ensured women were fully informed about the test and the possible implications before going ahead. Midwives or consultants provided de-brief appointments for women whose antenatal screening results identified anomalies.

The trust offered a birth afterthought service. This offered women and their families the opportunity to access an experienced midwife for up to one year following the birth of their baby and to take part in the debrief of their birth experience. Staff informed us this is particularly helpful for women who had gone through traumatic birth.

The service liaised with the chaplaincy to provide emotional support to women.

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

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Women we spoke with said they had been involved in decisions about their choice of birth location and benefits and risks of each. They felt staff supported their decisions. Family members who were present at the time of our inspection informed us they felt included in the process.

Women said they had been given a range of information and were clear about their birth plans and explanations of treatment. Most women said doctors and midwives had answered their questions and were reassuring.

Our review of care records showed women were advised of their options at every stage of their pregnancy including when complications occurred. Staff recorded consent was obtained before caring out procedures in line with women’s care.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of most local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, facilities and premises were not always appropriate for the services that were offered.

Women were either referred to maternity services by their GP or could refer themselves to the hospital. Women were provided with relevant information about their pregnancy and care at the maternity unit. Mothers were provided with a newborn pack, which included relevant information about services they could access.

The service delivered women above 34 weeks gestation, pregnancies below 34 weeks were transferred to Lincoln Hospital site for delivery.

Community midwives offered antenatal booking appointments in community premises, mainly GP surgeries and community centres. Community teams covered a specific geographical area. This helped to ensure women had access to midwives in their local area. The service provided continuity of care for women before and after birth. In line with this, community midwives booked women for antenatal appointments. All the women we spoke to in the antenatal clinic confirmed...
they had a named midwife in the community.

An early pregnancy assessment unit (EPAU) ran weekdays for women in the very early stages of pregnancy who had concerns about their baby.

Women over 20 weeks attended the antenatal assessment unit for assessment of pregnancy specific concerns including reduced fetal movement, CTG monitoring or for concerns about pre-eclampsia.

There was also an option of home birth, which accounted for 146 deliveries across the trust between 31 December 2017 and 31 December 2018.

There were waiting areas in the maternity unit including a day room in M1 (antenatal and postnatal) ward. The day room was spacious with a bright ambience, sufficient seating arrangements, water and beverage.

Women had access to antenatal classes ran by midwives. This included active birth classes and other classes for women who had complex needs, for example weight management or diabetes.

The trust had employed specialist midwives to provide extra support to women and families with more complex needs. These included a consultant midwife leading on better births, bereavement midwife, new born screening midwives, safeguarding midwives, mental health specialist midwives, diabetes specialist, infant feeding midwife and midwife sonographers.

The labour ward had facilities for women with low-risk pregnancies to give birth to their babies. This included a birthing pool, relaxing lighting, birthing balls and stools.

The trust had an active maternity voices partnership and was also an active participant with Lincolnshire’s Local Maternity Systems to deliver Better Births Strategy and Implementation Plan for Lincolnshire.

However, facilities and premises were not always appropriate for the services that were offered. The service did not provide a designated midwifery led unit, although women who were deemed to be at low risk did receive midwifery led one-to-one care in labour within the consultant ward. Midwives made use of two rooms to provide midwifery led care.

In line with findings during our last inspection, there was still no dedicated bereavement room available for women and families suffering a bereavement. There was no designated room for a woman to deliver a still born baby or spend time with a partner and baby. Staff were sensitive to this need and told us they tried to provide comfort and privacy using existing labour rooms. Senior staff informed us they were seeking funds to convert a classroom on the labour ward to a delivery room for this purpose.

The bereavement midwife trained and supported staff to provide care for families following a pregnancy loss. The service had close links with the chaplaincy service and local funeral services which helped facilitate communication and arrangements in a timely way.

**Bed Occupancy**

Data received from the trust showed between June 2018 and May 2019, the bed occupancy levels for maternity at Pilgrim Hospital was 47.40% for the labour ward and 58.19% for the maternity ward compared with the England average of 58.2%. During this period, the unit was closed on two occasions due to capacity.
Meeting people’s individual needs
The service was inclusive and took account of most patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

There was a range of leaflets on display in the antenatal waiting areas providing information about antenatal classes and maternity care. Women could also access a range of information on the trust’s website.

Staff informed us they had a high proportion of non-English speaking women who attended the service and they had access to interpreting services either face-to-face or through a helpline. Staff informed us these included interpreters for sign languages. We saw there were signs written in European languages within the labour ward and leaflets were available in different languages.

Partners were allowed to stay overnight by women's bedside on the maternity ward. Some of the chairs by the bedside were reclining chairs and staff informed us partners could bring in a sleeping bag if they wished. The new M1 maternity ward included separate gender neutral shower facilities that could be used by partners.

All showers within the maternity unit could accommodate wheelchair users.

Breastfeeding support was provided and the unit advertised the values of breastfeeding to mothers and staff.

Families were offered support towards the cost of parking. Information displayed within the unit provided contact details for families to approach members of staff in order to obtain support in a confidential manner.

Staff had access to mental health services and referred women were necessary. Women could access the lead nurse for learning disabilities and midwives referred them as appropriate.

At the last inspection, we found there were no specialist midwifery teams to support vulnerable women during pregnancy. During this inspection, we noted the service relied on three safeguarding midwives to support vulnerable women. This included a perinatal mental health safeguarding midwife. Although the safeguarding team indicated the trust could benefit from additional specialist midwives to support teen pregnancy, substance misuse or domestic abuse, they stated they were able to manage the workload safely.

Not all labour rooms had en-suite toilets, which meant a woman in labour would have to either use a commode in her labour room or dress up and move across the corridor to use the toilet. This could be undignified, uncomfortable or disruptive to the relaxation of women.

The service had a quiet room on M1 maternity ward where staff could have discussions with women and their families.

Access and flow
People informed us they could access the service when they needed it and received the right care promptly. However, the trust did not routinely audit waiting times to ensure they were in line with national standards.

Although women told us they could access the service when they needed it, the trust did not routinely audit waiting times to ensure they were in line with national standards.
During the period April 2018 to March 2019, 66% of women booked their maternity appointment 12+6 weeks of pregnancy. This was higher than the trust target of 52%.

At the last inspection, the trust did not collect data relating to the percentage of women seen by a midwife within 30 minutes and if necessary by a consultant within 60 minutes during labour. We requested for this data following our recent inspection, but it was not provided.

However, we noted good patient flow across the maternity units. Women in labour were provided 1:1 care and staff attended promptly to women on the maternity ward.

The elective caesareans were performed in the main theatres with support of nominated theatre and midwifery staff. This meant that women’s operations were never delayed by emergency surgery.

Women informed us they found it easy to make appointments with the antenatal team. Some of the women we spoke with had been in the unit for over an hour, although they had already seen a midwife and were waiting to have a scan. The trust did not routinely audit waiting times for women seen in the antenatal clinic.

Staff across the service used an electronic system to monitor bed vacancies and inductions of labour. If the workload was unsafe, women could be diverted to another hospital.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patient Advice Liaison Service (PALS) information leaflets were displayed in clinical areas and information about contacting PALS was available on the trust’s website.

The women we spoke to told us they were aware about how to make a complaint. They told us they could raise any concern to ward staff if they needed to. Staff had awareness about the complaint process and could signpost women accordingly.

We saw minutes of staff meetings addressed complaints raised by women and lesson learned was shared with the wider team.

**Summary of complaints**

From March 2018 to February 2019 the trust received 20 complaints in relation to maternity at the trust (2.8% of total complaints received by the trust). The trust took an average of 55.2 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 35 working days, or 50 working days for more complex complaints. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>12</td>
<td>60.0%</td>
</tr>
<tr>
<td>Values and Behaviour</td>
<td>3</td>
<td>15.0%</td>
</tr>
<tr>
<td>Patient care</td>
<td>3</td>
<td>15.0%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Pilgrim Hospital**
From March 2018 to February 2019, Pilgrim Hospital received six complaints in relation to urgent and emergency care. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>4</td>
<td>66.7%</td>
</tr>
<tr>
<td>Values and Behaviour</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td>Patient care</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From March 2018 to February 2019, there were 278 compliments about maternity at Pilgrim Hospital. A breakdown of compliments by department is below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>March 2018 to February 2019</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of compliments</td>
<td></td>
</tr>
<tr>
<td>Labour</td>
<td>178</td>
<td>64.0%</td>
</tr>
<tr>
<td>M1 / Maternity Ward</td>
<td>100</td>
<td>36.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>278</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The maternity service sat within the Family Health Division. There was a clear leadership structure across the trust which included a managing director, a clinical director and head of nursing and midwifery.

The maternity service at Pilgrim Hospital was led by a matron. Staff informed us a lead midwife had been recruited for Pilgrim Hospital and was due to resume within a month of our inspection. Band 7 ward managers supported the matron on the ward. A Band 7 midwife led antenatal clinics across Pilgrim Hospital and Lincoln Hospital.

We found clear lines of accountability and responsibility on the units and staff understood their roles and how to escalate problems.

The clinical directors were supported by a team of consultants. Doctors felt supported by the wider team as well as medical colleagues and told us they received good support from the consultants.

Staff informed us the leadership was visible and approachable. Senior local staff told us they met regularly with the head of midwifery and had close working relationship with the divisional leadership.
Midwives had access to a Professional Midwifery Advocate (PMA). This is a leadership and advocacy role designed to deploy the A-EQUIP model. A-EQUIP is an acronym for Advocating for Education and Quality Improvement. The A-EQUIP model supports a continuous improvement process that aims to build personal and professional resilience of midwives, enhance quality of care for women and babies and support preparedness for appraisal and professional revalidation.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a vision to provide excellent specialist care to the people of Lincolnshire and collaborate with local partners to prevent or reduce the need for people to be dependent upon their services. Staff were aware of the trust values; patient centred, safety, excellence, compassion and respect. The trust’s vision and values were clearly visible on information boards in clinical areas.

The trust had a five year strategy 2019 to 2024 which set priorities for the trust and objectives for delivery. The trust aimed to move away from reactive, hospital-based treatment where possible, towards proactive healthcare in partnership with other stakeholders.

The vision for the maternity unit aligned with the trust’s commitment to maintain obstetric services alongside midwifery led units across two sites at Pilgrim Hospital and Lincoln Hospital. Senior staff informed us they were working towards delivering standards in line with the better birth strategy and national maternity strategy.

Plans to improve the physical environment of the maternity block with the provision of an antenatal and postnatal ward had been implemented. The M1 maternity ward was open by the time of our inspection and provided modern facilities for antenatal and postnatal care.

The trust was part of Lincolnshire’s Local Maternity Systems (LMS), which was set up by Lincolnshire’s maternity stakeholders (including clinical commissioning groups, providers and service user partnerships) to deliver Better Births Strategy and Implementation Plan for Lincolnshire 2017 – 2020/21. Key details in the plan include increasing the home birth rate, increasing midwifery led care and reduction of the still birth rates.

Senior staff were engaged with delivering the better births strategy and were activity involved with the LMS transformation group.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff reported there was a positive culture within the service. Staff felt they had opportunities to develop in their role and said they had good working relationships with other team members. Staff were focussed on delivering excellent care in line with the trust vision.

Staff said the unit was open and transparent and they could raise concerns with senior staff. Staff understood their responsibility under the duty of candour regulations and could follow the correct process. Women we spoke to also confirmed they could raise any concerns with staff if required.

Junior doctors confirmed they had access to training and good support from consultants. Nurses also had access to development training.
Staff we spoke with felt well supported at work. One student midwife said they had “excellent overall experience” across both community and hospital settings. They confirmed they received good support and encouragement from their mentor and had applied for permanent position on completion of their training.

The service supported a number of staff wellbeing initiatives with the aid of the occupational health team. This included the opportunity to benefit from yoga classes, massages and pedicure.

There was a dedicated Freedom to Speak Up Guardian who supported all staff, most staff we spoke with knew who they were, what their role was and how to contact them.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The maternity service sat within the Family Health Division. This included gynaecology and children and young people’s services.

There was a robust governance arrangement within the division. This included monthly speciality governance meetings where senior staff reviewed for example, patient safety, performance, safeguarding, patient experience, clinical effectiveness, risk management and education.

The speciality governance meeting reported to the divisional clinical cabinet which in turn reported to the quality and safety oversight group.

Staff also attended monthly maternity quality review meetings, matron meetings, Band 7 midwives team meetings and maternity ward meetings. There were also weekly Cardiotocography (CTG) review meetings.

Mortality and morbidity presentation was held monthly and involved multidisciplinary team members (MDT). We reviewed presentations from the last three meetings and saw staff reviewed cases in detail with areas of good practice highlighted, together with learning outcomes.

**Management of risk, issues and performance**

Leaders and teams did not always use systems to manage performance effectively. Staff contributed to decision making to help avoid financial pressures compromising the quality of care. However, there were inefficient systems for identifying and escalating risks.

The service had a risk midwife who reviewed all maternity incidents, themes and trends.

The service conducted monthly audits to monitor performance against established standards. A maternity dashboard provided an overview of performance against clinical indicators. Whilst the Pilgrim Hospital maternity dashboard showed the service achieved some good outcomes for patients, there were still areas requiring improvement. The still birth rate, proportion of women having induction of labour and proportion of blood loss (greater than 1500mls) was higher than the national average. We noted performance was regularly reviewed by staff during clinical governance and staff meetings.

The service did not routinely audit waiting times. This meant the trust was not assessing this performance against national standards.

Divisional performance reports were produced, monitoring operational performance, finance, quality and workforce indicators. The purpose was to provide an insight into how the individual directorates contributed to the overall trust performance. Issues arising from the performance
meetings were escalated to the relevant Board committee and to the Trust Management Group where appropriate.

During our inspection, we asked to review the local maternity risk register. However, local staff found it difficult to articulate which local risks were on the risk register. Staff told us they updated the risk register on an electronic system. We noted risks were collated centrally on a corporate/business unit level and staff told us they often required the assistance of the risk manager to add risks to the risk register.

Data received from the trust’s routine provider information request included the ‘ULHT Business Unit Risk Registers’ (a 607 page document) which included risks regarding many specialities across the trust. Following our inspection, we requested for the local risk register for the maternity unit and we were provided with a risk register for the Family Health division. There were 12 risks on the divisional risk register. Each risk was given an overarching title and sub-divided to several risks relating to each speciality. Of these, 13 sub-risks referred to issues pertaining to the obstetric speciality. Planned action to reduce each risk were listed, along with the lead responsible for taking action.

The overarching title, description and controls in place for each of the main risks were generic in nature. Each sub-risk identified ‘weaknesses or gaps in control’ which then gave a description of the risk in relation to different specialities (obstetrics, breast surgery and gynaecology). For example, one of the risks on the risk register was titled ‘availability of essential information’. The description outlined potential consequences if information essential to the provision of services by the business unit was not available when required. Controls in place indicated there was capital investment planning and procurement for information technology. It then provided a breakdown of ‘weaknesses or gaps in control’ regarding three separate specialities within the business unit. In relation to the obstetric service, it stated CTG recordings were prone to fading, becoming damaged or lost during storage and they may not be available or readable when needed for medico legal purposes. Planned mitigating action associated with this stated CTGs were stored in purpose designed envelopes to minimise damage or loss. In addition, CTG archiving would be included in the new maternity electronic system.

The risk register contained several duplications. For instance, risks related to the lack of bariatric equipment and facilities were contributory factors under several risk titles and different planned actions were listed.

Senior staff informed us one of the risks for the maternity unit was the lack of an emergency buzzer system on labour ward. Although was not listed on the risk register for women’s health at the time of our inspection, we noted it had been added to the updated risk register received following our inspection. To mitigate this risk, staff used a draw string call bell which they pulled trice to alert other staff about an emergency during labour. Staff said they regularly informed locum and new doctors that a call bell was in use for this purpose. The planned action on the risk register was to arrange for the installation of a WI-FI emergency call bell system for Pilgrim Hospital labour ward with a due date of 31 July 2019.

Staff in the antenatal clinic identified scanning capacity as one of the risks on the maternity unit. This was referenced as a contributory factor (or weaknesses or gaps in control) in relation to the risk titled ‘compliance with regulation and standard’. It indicated the trust was only able to offer scans on four weekly basis to women identified as high risk for ‘small for gestational age’ (SGA) or fetal growth restriction (FGR). The trust was unable to offer routine scanning to women with BMI of 35 – 39.99. This was not in line with GAP and GROW guidance which states all women identified as high risk for SGA/FGR should be scanned every three weeks. This included women with a BMI that was greater than 35. This was identified as a high priority risk. Planned action included drafting a business case for approval, implementing additional drop in sessions, and providing the required scans every three weeks. The risk register indicated community midwives were seeing women every three weeks to conduct fundal height measurement which reduced the risk of
missing potential SGA/FGR. The action due date was in March 2019; however, it was unclear if any progress had been made in this regard.

We raised issues regarding the risk register with the divisional leadership team. They identified the risk register was revised in a board level format with an overarching title that was not appropriate for clinical risk. They informed us they were working with the risk team to have standard operating procedures to manage risks internally.

The service had maternity safety champions to ensure women and their babies received the safest care possible. The maternity safety champions included the divisional head of midwifery, a consultant obstetrician and gynaecologist and the head of service for obstetrics.

(Source: DR126)

Information management
The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to a range of information to enable them understand performance and make decisions to improve it. The maternity dashboard was easily assessible and displayed in clinical areas. It was red, amber and green (RAG) rated enabling staff to quickly recognise areas requiring improvement.

Detailed information regarding performance, risks, education and training, incidents and trends were displayed in staff rooms.

Staff informed us they could access information they needed to provide safe and effective care. Staff had access to patient records and this included clinical notes from the multidisciplinary team and results of investigations carried out.

The intranet was available to all staff and contained links to guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained therein.

Electronic systems were password protected and we observed staff signing out of systems once they completed their tasks.

The service participated in national audits and submitted data to external organisations for this purpose.

Engagement
Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged patients through feedback forms. Feedback from patients were positive with the service regularly receiving 100% recommendations on a monthly basis.

The service displayed information throughout the unit to educate women about healthy options for pregnancy, services provided by the trust as well as information about what staff were doing. For example, staff use of hand held devices were displayed in pictorial format to make women aware that staff used electronic hand held devices to record observations and were not texting on a phone when they should be working.
The trust engaged with staff through emails, meetings, information on notice boards and catch up meetings held on daily basis. Staff informed us they were involved with the planning and designing of the new M1 maternity ward.

The service encouraged staff to nominate other outstanding staff for the yearly staff awards evening.

The trust had an active maternity voices partnership (MVP), an advisory group made up of professionals and parents working in partnership, including staff, representatives of clinical commissioning groups (CCGs). The MVP worked together to review and contribute to the development of local maternity services.

The trust was partnering with Lincolnshire’s Local Maternity Systems to deliver the Better Births Strategy and Implementation Plan for Lincolnshire 2017 – 2020/21. Lincolnshire’s Local Maternity System had representation from key maternity stakeholders in Lincolnshire; who came together to ensure women, their babies and their families had equitable access to the services they chose and needed, as close to home as possible.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services although there were still areas requiring improvement. They had a good understanding of quality improvement methods and the skills to use them.

The service consistently reviewed incidents and any formal complaints at specialty governance meetings, matrons meetings and staff meetings. Learning from incidents, themes and trends were shared with the wider team and displayed within the staff coffee room.

One of the trust’s midwife emerged as the Midwife of the Year 2019 for the Midlands region. The midwife was nominated by a local mother. The award was one of the Royal College of Midwives (RCM) Annual Midwifery Awards, recognising the incredible work done by exceptional midwives across the country.

The antenatal clinic won the ‘star of the month award’. Senior staff were complimentary about the service’s birth choice clinics, which recently won the improvement education and research award in recognition of valuable contribution to the trust.

The service had opened a new M1 maternity (antenatal and postnatal) ward with modern facilities to enhance patient care. Staff are happy to work in the new unit and some of them informed us they were involved in planning the unit.

However, some of the areas of improvement identified during the last inspection had not been addressed. This included lack of bereavement facilities and lack of a designated midwifery led unit.
**Services for children and young people**

**Facts and data about this service**

The trust provides care for children and young people at Lincoln County Hospital and Pilgrim Hospital in Boston. Both hospitals provide paediatric services for children from newborn to 16 years of age including day case and emergency services.

There are 24 paediatric inpatient beds on Rainforest Ward at Lincoln County Hospital, an eight-bedded paediatric day case ward and one intensive care, two high dependency, 12 special care and four transitional care beds.

(Source: Routine Provider Information Request (RPIR) – Acute context)

At the time of the inspection there were eight paediatric assessment beds and four day case surgery beds on ward 4A at Pilgrim hospital and a neonatal unit with eight neonatal cots and four transitional care beds.

The trust had 6,359 spells from January 2018 to December 2018.

Emergency spells accounted for 97.5% (6,197 spells), 1.9% (124 spells) were day case spells, and the remaining 0.6% (38 spells) were elective.

**Percentage of spells in children’s services by type of appointment and site, from January 2018 to December 2018, United Lincolnshire Hospitals NHS Trust**

![Percentage of spells in children’s services by type of appointment and site](image)

**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>3,748</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>2,609</td>
</tr>
<tr>
<td>This trust</td>
<td>6,359</td>
</tr>
<tr>
<td>England total</td>
<td>1,141,379</td>
</tr>
</tbody>
</table>

(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 service provided mandatory training in key skills to all staff but did not make sure everyone completed it. Medical staff did not always receive and keep up to date with mandatory training.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training, with the exceptions of:

- Fraud awareness and infection prevention level one, which had targets of 95%.
- Local fire procedures and fire safety, which had targets of 100%.
- Immediate life support (ILS)/advanced life support (ALS) and medicine management training which had no targets. The trust informed us that the eligible numbers of staff were not available for these two courses and therefore we were unable to calculate completion rates.

A breakdown of compliance for mandatory training courses as of February 2019 for qualified nursing staff in the children’s services at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>43</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>43</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>43</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>43</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>42</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>42</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>42</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>42</td>
</tr>
<tr>
<td>Fire safety</td>
<td>41</td>
</tr>
<tr>
<td>Information governance</td>
<td>40</td>
</tr>
<tr>
<td>Basic life support</td>
<td>39</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>21</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>9</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital children’s services, the target was met for nine of the 11 applicable mandatory training modules for which qualified nursing staff were eligible. The remaining two modules were completed by over 90% of staff.

Two modules had no eligible staff numbers available and no completion target but had staff members who had completed the modules.

Medical staff did not always receive and keep up to date with their mandatory training.
A breakdown of compliance for mandatory training courses as of February 2019 for medical staff in the children’s services at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>16</td>
</tr>
<tr>
<td>Slips, trips &amp; falls</td>
<td>16</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>16</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>16</td>
</tr>
<tr>
<td>Fire safety</td>
<td>16</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>16</td>
</tr>
<tr>
<td>Local fire procedures</td>
<td>14</td>
</tr>
<tr>
<td>Fraud awareness</td>
<td>14</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>14</td>
</tr>
<tr>
<td>Basic life support</td>
<td>13</td>
</tr>
<tr>
<td>Information governance</td>
<td>13</td>
</tr>
<tr>
<td>ILS/ALS</td>
<td>10</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital children’s services, the target was met for four of the 11 applicable mandatory training modules for which medical staff were eligible. The remaining module had no eligible staff number available and no completion target but had staff members who had completed the module.

(Source: Routine Provider Information Request (RPIR) – Training tab) The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training covered key skills for staff. In addition to the modules reported above, the trust provided training in sepsis awareness. The identification and management of sepsis was a focus for improvement for the trust and staff told us of the work being done to ensure sepsis was considered whenever a patient showed signs of deterioration in their condition. Data provided by the trust showed 100% of staff in children and young people’s services across the trust had completed an e-learning programme on sepsis.

Staff completed paediatric immediate life support training and nurses completed advanced paediatric life support (APLS) or European paediatric life support (EPLS). Information provided by the trust showed that whilst all nurses had not completed this training, there was always one member of staff on the ward with the qualification. When children were in the operating theatre recovery area following surgery, managers ensured one member of staff caring for the child had completed APLS or EPLS.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, but did not receive specific training in learning, disabilities and autism. Ward sisters told us staff completed training in child and adolescent mental health and staff we spoke with confirmed they had received training. Staff were not provided with specific training about learning disability or autism. The nursing team told us the emphasis was on asking individual parents and children what was important to them.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward sisters monitored completion of mandatory training for ward staff. Staff told us there was a flag on the electronic staff record when training was due and they, and their manager, received an email reminder. Ward sisters told us they reminded staff when their training was due. They showed us data for the current month during the inspection visit; this demonstrated the wards met trust targets for all mandatory training topics.
For medical staff, the senior management team said the clinical lead received monthly updates in relation to mandatory training and wrote to consultants to remind them that the training was required.

**Safeguarding**

**Staff did not always have training on how to recognise and report abuse.**

However, staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

**Safeguarding training completion rates**

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

Nursing staff and allied health professionals received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses as of February 2019 for qualified nursing staff in the children’s services at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February, 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Safeguarding children (level 3 additional)</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>42</td>
<td>43</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>41</td>
<td>43</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>37</td>
<td>43</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>37</td>
<td>43</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>37</td>
<td>43</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital children’s services, the 90% target was met for three of the six safeguarding training modules for which qualified nursing staff were eligible.

At the time of the inspection, a member of staff showed us evidence that 100% of staff in the neonatal unit had completed level three safeguarding children training. The percentage of staff on ward 4A who had completed level three safeguarding children training was 81%. The ward sister explained there were four new starters and two staff on maternity leave, accounting for a temporary drop in training rates. The new staff were booked onto this training. Staff working in the children’s outpatient department were up to date with level three safeguarding training.

Nurses working in the adult outpatient departments where children were regularly seen, such as the fracture clinic, told us all registered nurses completed level three children’s safeguarding training and health care assistants completed level two training. Radiographers working in X ray, MRI and CAT scanning departments, completed level three children's safeguarding training.

Awareness of child sexual exploitation was included in safeguarding training. Staff we spoke with showed a good awareness of these issues and were confident they would recognise possible indicators of child sex exploitation. Similarly safeguarding training included awareness of female genital mutilation.

Medical staff received training specific for their role on how to recognise and report abuse. However, trust data showed the percentage of medical staff receiving training did not meet trust targets.
A breakdown of compliance for safeguarding training courses as of February 2019 for medical staff in the children’s services at Pilgrim Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>14</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>14</td>
</tr>
<tr>
<td>Safeguarding children (level 3 additional)</td>
<td>9</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>12</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>12</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>12</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital children’s services, the 90% target was not met for any of the six safeguarding training modules for which medical staff were eligible.

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

Medical staff spoken with during the inspection confirmed they had received level three safeguarding children’s training. Some possible issues with the recording of training for medical staff in training, was identified as a cause of the lower compliance figures.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff completed equality and diversity training as part of mandatory training. Three staff we spoke with, were able to describe the protected characteristics and give us examples of possible discriminatory practices, although they said they had not had the need to report any concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Medical and nursing staff gave us examples of issues that might trigger a safeguarding concern and the actions they would take to report and liaise with other services, to ensure concerns were followed through. A member of staff gave us an example of a concern they had raised when they did not feel a father was bonding with their baby and they had concerns about their parenting capacity. They said they spoke with the safeguarding team and made the necessary referral. A member of staff in one of the adult outpatient departments gave us two examples of concerns they had raised, in one case liaising with the child’s school and a school nurse.

Information about safeguarding children was available on the trust intranet and in the clinical areas. We saw a variety of posters and displays about different aspects of safeguarding children designed for staff and patients.

The trust provided evidence that recommendations from county serious case reviews were actioned and completed by the trust.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff at Pilgrim hospital made 13 children’s safeguarding referrals from March 2018 to March 2019.

Staff were very clear about their responsibilities in relation to safeguarding children. They were aware of the procedures for reporting a concern and making a safeguarding referral. Each clinical area had a safeguarding link nurse to additional expertise and advice for staff. Staff said the safeguarding team were based on the Lincoln site; however, they were readily available by telephone or email and visited the hospital weekly.

Staff followed safe procedures for children visiting the ward and departments. The trust’s electronic patient record system enabled alerts to be put onto the system, when there were
safeguarding concerns for a patient. In this way, staff could immediately identify when existing safeguarding concerns were identified and share information with other appropriate agencies about attendances and concerns.

The named nurse for safeguarding received a monthly report containing details of children (under 16 years) admitted to adult-specific areas. These figures were reported to the trust safeguarding committee, as well as the paediatric surgical committee and children and young people’s steering group, to ensure appropriate risk assessments were undertaken. A process was in place where any child (under 16) who was admitted, was identified on the trust's risk management system and the safeguarding team were made aware.

Medical staff said they had a clear pathway and a standard multi-agency proforma for recording safeguarding issues and examinations.

Staff in the X ray department explained safe procedures for the management of X rays for suspected non-accidental injury in children and young people. Two senior radiographers and a children’s nurse were present and images were stored securely.

Staff had access to safeguarding supervision by the trust safeguarding team and they said they had formal de-briefing sessions as a group or on a one to one basis.

**Cleanliness, infection control and hygiene**

The service did not always control infection risk well. Staff did not always use control measures to protect children, young people, their families, themselves and others from infection.

However, staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were visibly clean and had suitable furnishings which were clean and well-maintained.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.9 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)

Parents we spoke with during the inspection, had no concerns about the cleanliness of the wards and clinical areas.

All wards were visibly clean including bed areas, bathrooms, toilets and play areas. We observed toys were made of materials that were easily cleaned. Signs in the patient areas asked parents to return toys to staff after use, to ensure they were cleaned before being made available to others. Domestic staff were present on the wards and we observed them completing cleaning duties thoroughly and systematically.

Staff in the children’s outpatient department explained domestic staff were allocated to the department during the morning when clinics were busy. They said they had asked for an evening or early morning cleaning slot but were unsuccessful in obtaining a change to the time allocation. As a result, staff completed additional ad-hoc cleaning to ensure cleanliness was maintained.

Managers conducted audits to monitor the cleanliness of the clinical environment on an ongoing
basis. Trust data indicated that high standards of cleanliness were maintained. The service audited environmental cleanliness monthly. Cleanliness scores for the neonatal unit were above 95% in each of the five months from January to May 2019. Cleanliness scores for ward 4A fluctuated, although improved from a score of 81% in January 2019 to 90% or above, following this.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. We observed cleaning schedules were available in all areas and staff completed checklists that showed daily cleaning of toys and games in each area was undertaken.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE) and did not routinely monitor audit compliance with procedures which have a high impact on infection.

The National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. Parents on ward 4A told us they saw staff using the hand sanitising gel. However, the positioning and number of hand sanitising gels was not ideal, and we found the gel was not clearly visible to visitors. One of our team reported that they observed staff for a period of 30 minutes on the children’s ward and they saw only one member of staff out of 10 observed, use the hand sanitiser when they should have been used.

Evidence provided by the trust showed that in monthly audits from January 2019 to May 2019, ward 4A scored 100% in their hand hygiene audit in May 2019 only, with performance in other months ranging from 80% to 95%. The neonatal unit scored 100% each month in the same period and the children’s outpatient department scored 100% in four out of the five months.

A piece of work was undertaken by the trust between January and March 2019 (quarter four) which changed the way in which hand hygiene was assessed. Prior to this the trust would receive consistent 100% hand hygiene compliance in most areas and recognised that this probably did not reflect actual practice. The trust therefore changed the hand hygiene assessment methodology to better reflect a more accurate position and to show the areas where non-compliance needed support. During quarter four, the infection prevention and control (IPC) team briefed the trust IPC committee to advise that they expected hand hygiene numbers to decline as the new assessment tool was rolled out. This guided the IPC team on where they needed to focus their efforts to support improvements.

We observed staff adhering to good hand hygiene practices on the neonatal unit and the children’s outpatient department. They were ‘bare below the elbows,’ washed their hands or used hand sanitising gel, before and after each patient contact. Parents commented that staff were very good at remembering to wash their hands. Personal protective clothing and equipment (PPE), such as aprons and gloves, were available within clinical areas and we observed staff using them when providing care.

The service did not routinely monitor staff compliance with procedures which are recognised as having a high impact on the prevention of infection in hospital patients. These are procedures that should be followed when inserting and caring for peripheral and central venous cannulas and urinary catheters. The trust told us they had plans to audit invasive procedures within the next three months. Staff completed documentation to show they adhered to good practice in the insertion and removal of cannulas and checked for signs of inflammation and infection daily. Records we reviewed during the inspection showed that staff mostly completed the documentation and adhered to the requirements.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. There was a sticker system in place, which indicated equipment had been cleaned and we observed that stickers had been placed on equipment and showed they had been cleaned recently.
Environment and equipment
The design and use of facilities, premises and equipment did not always keep people safe. However, equipment was maintained and staff managed clinical waste well.

Children, young people and their families could reach call bells and staff responded quickly when called. A call bell system was in place on ward 4A that enabled children and their families to call for assistance when required, and for staff to summon help in the case of an emergency. Parents told us they did not normally need to use the call bell, as staff were attentive to their needs and were visible in the clinical areas. However, when they asked for assistance, staff responded promptly.

The design of the environment did not always follow national guidance. The operating theatres had sufficient paediatric equipment to maintain safety. However, Royal College of Anaesthetists (RCA), guidelines for the provision of anaesthesia services (2019) state that, "Children should be separated from, and not managed directly alongside adults throughout the patient pathway, including reception and recovery areas. Where complete physical separation is not possible, the use of screens or curtains, whilst not ideal, may provide a solution." At the Pilgrim hospital, children shared the same recovery area as adult patients. On the lower floor, there was a separate bay for children and the use of curtains prevented any overlooking from adults in other bays. On the upper floor, separation was achieved by using bed curtains to screen a bed space. Compliance with the RCA guidelines was therefore achieved, but it was not ideal. Staff told us they were in the process of submitting plans to fully separate, adults and children in recovery.

Ward 4A and the neonatal unit had secure entry systems. Staff were able to enter using an electronic card entry, while visitors were required to use an intercom at the entrance to each area. This was answered by nursing or reception staff and people’s identity was checked prior to entry. This meant staff had control over people entering the unit. However, there was a lift that directly opened onto the children’s ward. The lift was operated using a key coded pad. Staff told us it was only accessible to porters, however, if the code was discovered by other people, it would enable them to enter the ward directly without going through a staff check.

Ward 4A had two four bedded bays and the remainder of the beds were provided in side rooms. As a result, single rooms were available for those patients with infections and the accommodation was flexible enough to accommodate adolescents or young babies in single rooms if they wished. There was also space for a parent to stay by the bedside if they wished and single beds were provided for this purpose.

Ward 4A included a treatment and stabilisation room for very sick children. There was piped oxygen and suction to every bed space on the wards and in the treatment and stabilisation room. The treatment and stabilisation room were fully stocked with emergency equipment and medicines in locked cupboards.

The neonatal unit had eight incubators or cribs, an isolation room for babies with infections and a transitional care bay with four beds and cribs for mothers and babies. These were all supplied with piped oxygen and suction.

Staff carried out daily safety checks of specialist equipment on the children’s ward and neonatal unit. However, safety checks of specialist equipment were not always completed in the operating theatres and there were no paediatric drugs on the paediatric resuscitation trolley in theatres. All ward and clinical areas had a resuscitation trolley, with resuscitation equipment and drugs suitable for children and young people. These were secured in areas away from the public and had tamper proof tags to identify if any of the equipment had been accessed. Daily checks were kept of the emergency equipment in the paediatric ward, neonatal unit, and outpatient departments. Child and baby sized equipment was provided. However, we found the tamper proof tag on the resuscitation trolley on ward 4A was broken when we checked it on one occasion during the inspection. We alerted ward staff and an immediate check of the contents was undertaken and the tag replaced.
The theatre recovery area had an airway management trolley stocked for children and a paediatric resuscitation trolley. However, there were no paediatric drugs on the resuscitation trolley and daily checks of the trolley were not always completed. The trust resuscitation policy stated that every resuscitation trolley should have one drugs box.

The treatment and stabilisation room on ward 4A had an anaesthetic machine that was checked daily by theatre staff.

The service had suitable facilities to meet the needs of children and young peoples’ families. The paediatric wards and the neonatal unit had kitchen facilities to make hot drinks and basic meals. There was also a parents’ room and single en-suite rooms in each area for parents who stayed overnight. Parents were provided with lidded containers for hot drinks if they wished to bring them into the ward, to reduce the risk of scalds.

The service mostly had enough suitable equipment to help them to safely care for children and young people. The children’s wards and the neonatal unit had the beds and equipment required to keep children and babies safe. Staff told us they had good access to the equipment they needed. However, two members of staff raised an issue in respect of the availability of a piece of equipment that was not available for the diagnosis of asthma in children. NICE (NG80) Asthma: diagnosis, monitoring and chronic asthma management, recommends the use of FeNO2 as an objective test for asthma in children. There was no equipment in trust for this purpose, although we were told some GP practices had it. Consultants supported the need; although we were told it was a cost issue.

All new medical equipment was delivered through the medical engineering department and entered onto an asset management database. A maintenance plan was established for all items and entered on the database; the equipment was labelled with the equipment number and the next service due date.

We checked 25 pieces of equipment in the clinical areas and found they were all serviced and tested for electrical safety, in line with requirements.

Staff disposed of clinical waste safely. Clinical waste was appropriately stored and disposed of. In all clinical areas, there was correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with the Health Technical Memorandum 07-01, ‘Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations’. Sharps bins were labelled, and the bins were not overfilled.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and did not always take action to remove or minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients but did not always calculate the score and escalate them appropriately. A neonatal early warning score was used on the neonatal unit and calculated at each set of observations.

An audit of 40 observations charts in the neonatal unit was completed of babies admitted in 2017. This showed the following areas for improvement:

- Scoring frequency was not always adhered to
- Repeat observations were not always performed within an hour
- Escalation to medical staff was not always documented
- Occasionally not all parameters and patient demographics were completed
A repeat audit was planned within six months however, we were not provided with evidence of any further audits following this. We reviewed the investigation of a serious incident that occurred in the neonatal unit in June 2018 and found staff had not always calculated the neonatal early warning score correctly. Although an action plan was developed in relation to the incident and the correct use of the score was listed, there was no action to provide re-training on the use of the score, or to complete a further audit to check whether the score was generally being used correctly. This gave us concerns about the follow up of safety issues and learning from incidents.

A paediatric early warning score (PEWS) was used to identify signs of deterioration in patients on ward 4A. This was completed each time nursing staff undertook vital signs observations. The score was calculated electronically and was updated on the ward electronic white board, which showed whether the score had gone up or down compared to the previous score and when the next observations were due. However, we found PEWS was not used in theatre recovery areas. Staff told us their current proforma used did not require a score to be used and staff were working on the paediatric pathway, with the intention of incorporating PEWS in the future.

The trust did not provide any results of audits of staff completion and escalation of PEWS scores. However, they did provide evidence of compliance with sepsis screening and management, the results of which are reported below. In order for a sepsis screen to be triggered, the PEWS would be calculated.

We reviewed the records of observations and PEWS for four children and young people and neonatal early warning scores for five babies and found they were completed appropriately. None of the scores had required escalation, so we could not check whether staff escalated the score appropriately. However, staff told us medical staff responded quickly when they escalated a deterioration in a patient’s condition. They told us they would have no hesitation in escalating a concern to a more senior doctor or consultant, if they felt it necessary. They said the consultants were happy to be contacted if they had a concern and would attend if required.

Medical staff said they felt PEWS was well embedded and the escalation policy was clear.

Staff had access to the local children’s and neonatal intensive care decision support and transfer services for advice on, and transfer of, critically ill children and babies. They followed protocols and advice from the teams and had regular liaison with them when there were delays in transferring babies and children due to capacity issues at tertiary hospitals. For example, staff told us of a neonate requiring level 2 intensive care who required assisted ventilation (CPAP) who they discussed with neonatal network. The baby was stabilised and stayed in the unit. Staff said the if a situation occurred when a baby or child required intensive care and couldn’t be moved to a tertiary centre, they completed an exception report form.

A policy for the transfer of the critically ill babies, children and young people, was in place (dated June 2017). It provided clear criteria for patients for transfer to other hospitals and the process to be followed. A draft updated guideline for the transfer of babies and children externally and internally within the trust was provided following the inspection.

Staff completed risk assessments for each child and young person on admission / arrival and updated them when necessary and used recognised tools. Nursing and medical staff completed a full assessment of each patient when they were admitted. Nursing assessments included assessments of risk of developing pressure ulcers, moving and handling assessments, and risk of carriage of resistant organisms including carbapenemase resistant enterococci (CPE). We reviewed eight sets of records and found the assessments were completed consistently.

Staff completed pre-operative assessments for children being admitted for planned surgery. Due to the facilities available at the hospital, children under five years of age were not admitted for planned surgery. The service used the American Society of Anaesthesiologists (ASA) grading system to pre-assess patients’ level of risk for general anaesthesia. Children and young people assessed as being at low risk (ASA level 1 or 2) were treated at the Pilgrim hospital. Children at higher risk were admitted to Lincoln County hospital. Some emergency paediatric surgery was completed, when delay due to transfer to an alternative hospital would result in adverse outcomes
for the child, e.g. torsion of the testis (restriction of blood flow to the testicle, that causes severe pain and can result in loss of the testicle).

Staff knew about, but did not always deal with, (or were able to deal with), specific risk issues. The operational policy of the paediatric assessment unit stated patients should stay on the unit for a maximum of 12 hours and those who were unable to be discharged within that time frame, should be transferred to an inpatient unit at Lincoln County hospital, or one of the surrounding tertiary hospitals. This was agreed with stakeholders, to reduce risks, due to challenges around staffing of the unit and the high use of temporary staff. However, patients were not always transferred to other hospitals in line with the operational policy of the service, due to issues with transfer. The trust had commissioned a private ambulance service to transfer children when the need arose, to ensure timely transfer and reduce delays. However, the service could not transfer children with level one high dependency needs, such as the requirement for high flow oxygen or intravenous therapy. Therefore, these patients stayed on the unit for a longer period until their needs reduced.

Senior clinical staff had also made the decision not to transfer children with newly diagnosed diabetes, as if they were transferred out of county, as teaching regarding the management of their diabetes was not the same as within the trust. There were also exceptions made when children required emergency surgery. Three members of staff commented that this resulted in patients with high dependency needs being kept on the unit and less unwell patients being transferred. This meant the risks were not fully managed.

The identification and management of sepsis, although improving, did not meet trust targets. At the beginning of 2019 the trust identified some issues with the completion of documentation to aid the identification and management of sepsis. The trust’s sepsis e-learning programme was extended to include paediatric and maternity modules and there was an increased focus on sepsis within the division. By May 2019, all staff on ward 4A had completed the e-learning. Staff were also required to complete a sepsis workbook; this had been completed by 51% of staff by May 2019. We observed displays on the wall in the children’s ward and the neonatal unit about the sepsis care bundle that was being used and staff told us the electronic PEWS had prompts for sepsis. The ward had a sepsis link nurse. Monthly audits were completed and individuals responsible for sepsis screening were identified and followed up to ensure they understood the requirements. Audits completed in May 2019 showed, 77% compliance with initial sepsis screening on ward 4A and 100% compliance with the administration of antibiotics and the six sepsis actions within an hour. A senior nurse identified possible data quality issues, as they said the sepsis link nurse checked all omissions from the audits and found most had been completed on the electronic system.

When children and young people were admitted for surgical procedures, nursing staff completed a pre-operative checklist prior to their transfer to the operating theatre, to ensure all risks were systematically checked prior to surgery. We reviewed the checklist for seven surgical patients and found they had been completed fully. The trust used a four step process of checking that the site for the procedure was marked on the patient’s skin, prior to surgery. However, we identified there were only two out of four required checks completed in one child’s records. These checks are necessary to reduce the risk of errors occurring during surgery.

To reduce and potentially eliminate errors occurring in the operating theatre, the trust used the World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. From March 2018 the trust had used the WHO checklist on their theatre management system. They said that monthly reports demonstrated 100% compliance as completion is mandatory and users could not move forward without completing the WHO and discrepancies were picked up by theatre schedulers.

The service did not always have 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person’s mental health). Staff told us they had good relationships with the child and adolescent mental health service (CAMHS) and they were able to seek advice. They notified the team if a child or young person was admitted who was known to the CAMHS. However, CAMHS did not accept referrals for assessment of children and young people, not previously known to the service, until they had completed their medical treatment.
Staff completed or organised psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. (AMSAT) Staff completed a risk assessment for children and young people with possible mental health needs and they said they were able to obtain additional staff to provide one to one care if required. When their medical treatment was completed, CAMHS attended to complete an assessment of the child or young person within 24 hours of referral.

Staff shared key information to keep children, young people and families safe when handing over their care to others. When patients were discharged staff sent a discharge summary to the patient’s GP. Records we reviewed showed they contained the relevant information. Staff also used structured assessments and documentation to ensure pertinent information was communicated when liaising with other services such as when making safeguarding referrals and when the specialist transport services were used.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.8 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 9.5 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.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Shift changes and handovers included all necessary key information to keep children and young people safe. A medical staff handover was undertaken three times daily and a nursing staff handover was given at the start of each shift. We attended a medical staff morning handover and observed the attendance included the paediatric consultant on call and the ‘hot week’ consultant, junior doctors and the nurses in charge of the children’s ward and the neonatal unit. There was a full discussion of each patient, their progress and treatment plan and safeguarding issues were noted. They also discussed bed capacity and status and tasks were assigned to specific staff.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of all grades to keep children and young people safe. Although the data provided by the trust and detailed below, showed significant shortfalls in nursing staff numbers and high vacancy rates on ward 4A, senior nursing staff said the numbers were based on the staff required for 19 beds. Currently, managers were limiting the bed capacity to 12 beds. The trust had recently been successful in recruiting new staff to the ward; they had previously employed additional nursery nurses to compensate for shortfalls in registered nurses.

Two regular agency nurses, who had been working for the trust for over a year, complemented trust nurses at night.

Trust level

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for children’s services.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2017 to March 2018</th>
<th></th>
<th>April 2018 to February 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
<td>Staffing rate (%)</td>
<td>Actual staff</td>
</tr>
</tbody>
</table>

United Lincolnshire Hospitals NHS Trust Post-inspection Evidence appendix
From April 2017 to March 2018, the nursing staffing rate within children’s services was 82.8%. This was higher than the rate of 78.5% from April 2018 to February 2019. Both the actual number of WTE staff in post and the number of planned WTE staff increased in the more recent period.

Fill rates of more than 100% indicate there were more WTE in post than originally planned.

**Pilgrim Hospital**

Pilgrim Hospital reported the following WTE nursing staff numbers for the periods below for children’s services.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Special care baby unit</td>
<td>14.2</td>
<td>17.3</td>
</tr>
<tr>
<td>Paediatric outpatients</td>
<td>1.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Ward 4A</td>
<td>20.1</td>
<td>27.6</td>
</tr>
<tr>
<td>Community children’s nursing team</td>
<td>3.0</td>
<td>4.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39.0</strong></td>
<td><strong>50.9</strong></td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the nursing staffing rate within children’s services at Pilgrim Hospital was 76.7%. This was higher than the rate of 69.8% in the more recent period from April 2018 to February 2019. Although the number of actual WTE in post has not changed, the number of planned WTE has increased leading to a lower fill rate.

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

**Vacancy rates**

The service had high vacancy rates, however, the formal nursing establishment had not been reviewed following a reduction in bed capacity. The service had been successful in recruiting new staff.

**Trust level**

From April 2018 to March 2019, the trust reported a vacancy rate of 21.0% for nursing staff in children services. The trust stated that they did not have an overall target vacancy rate. There were separate targets for different staff groups, however, these were not specified.

- Lincoln County Hospital children services department: 23.1%
- Pilgrim Hospital children services department: 27.3%

A breakdown of vacancy rates by ward is below:

**Pilgrim Hospital**
### Ward / team name

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community children’s nursing team</td>
<td>35.4%</td>
</tr>
<tr>
<td>Ward 4A</td>
<td>34.5%</td>
</tr>
<tr>
<td>Paediatric outpatients</td>
<td>19.5%</td>
</tr>
<tr>
<td>Special care baby unit</td>
<td>12.8%</td>
</tr>
</tbody>
</table>

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

### Turnover rates

The service had turnover rates below the trust target. The neonatal unit had a higher turnover rate but the overall number of staff was low due to the size of the unit and this impacted on the turnover rate.

### Trust level

From April 2018 to March 2019, the trust reported a turnover rate of 6.3% for nursing staff in children services. This was lower than the trust target of 8%.

- Lincoln County Hospital children services department: 5.1%
- Pilgrim Hospital children services department: 7.4%

A breakdown of turnover rates by ward for each site is below:

#### Pilgrim Hospital

Only two wards at Pilgrim had turnover recorded from April 2018 to March 2019:

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special care baby unit</td>
<td>13.1%</td>
</tr>
<tr>
<td>Ward 4A</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

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

### Sickness rates

The service had sickness rates above the trust target. Processes were in place to manage sickness, absence.

### Trust level

From April 2018 to March 2019, the trust reported a sickness rate of 5.3% for nursing staff in children services. This was higher than the trust target of 4.5%.

- Lincoln County Hospital children services department: 5.6%
- Pilgrim Hospital children services department: 5.9%

A breakdown of sickness rates by ward for Pilgrim Hospital is given below:

#### Pilgrim Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community children’s nursing team</td>
<td>10.5%</td>
</tr>
<tr>
<td>Ward 4A</td>
<td>5.9%</td>
</tr>
<tr>
<td>Special care baby unit</td>
<td>5.5%</td>
</tr>
<tr>
<td>Paediatric outpatients</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
Ward sisters described the arrangements for return to work interviews for staff and the way sickness absence was monitored. A nurse told us they had been asked to attend a meeting to review their sickness, as they had been absence on three occasions in the recent past. They told us they had discussed the reasons for their absence and had been offered support.

**Bank and agency staff usage**

The service had low rates of bank and agency nurses used on the wards.

**Trust level**

The table below shows the numbers and percentages of nursing hours in children services at trust level from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 241,372 total working hours available, 2.8% were filled by bank staff and 5.4% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 9.2% of the available hours with either bank or agency staff.

Of the 87,248 total working hours available, 5.4% were filled by bank staff and 0.1% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 23.0% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total hours available</th>
<th>March 2018 to February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Qualified staff</td>
<td>241,372</td>
<td>6873.7</td>
<td>2.8%</td>
<td>13,098</td>
<td>5.4%</td>
</tr>
<tr>
<td>Non-qualified staff</td>
<td>87,248</td>
<td>4708.3</td>
<td>5.4%</td>
<td>112</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

**Pilgrim Hospital**

The table below shows the numbers and percentages of nursing hours in children services at Pilgrim Hospital from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

**Qualified nursing staff**

Of the 97,245 total working hours available, 1.1% were filled by bank staff and 5.0% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, the trust was not able to fill 14.5% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total hours available</th>
<th>March 2018 to February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Neonatal unit</td>
<td>33,887</td>
<td>159</td>
<td>0.5%</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Non-qualified nursing staff section

Of the 37,328 total working hours available, 1.8% were filled by bank staff and 0.0% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, the trust was not able to fill 36.5% of the available hours with either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total hours</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>available</td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Neonatal unit</td>
<td>15,858</td>
<td>176</td>
<td>1.1%</td>
<td>0</td>
</tr>
<tr>
<td>Ward 4A</td>
<td>21,470</td>
<td>511</td>
<td>2.4%</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>37,328</td>
<td>687</td>
<td>1.8%</td>
<td>0</td>
</tr>
</tbody>
</table>

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

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. The trust used national tools such as the safer nursing care tool, Royal College of Nursing paediatric standards, British Association of perinatal medicine (BAPM) standards, NICE quality standards and NHSI safe staffing guides to inform decision making in relation to the number of staff required. A workforce review was being undertaken at the time of the inspection and senior nurses said they felt there were sufficient staff for the ward at the current time. When the numbers of beds were reduced on ward 4A and the new operating policy was introduced to change the ward to a short stay unit, a decision was initially made to maintain the current staffing levels until a decision was made about the long term operating policy.

The ward manager could adjust staffing levels daily according to the needs of children and young people. The ward sister discussed staffing levels with the matron daily and adjustments were made as required. For example, when a child or young person was assessed as being at potential risk of self-harm, an additional member of staff could be requested to provide one to one care when necessary.

The trust had standard operating procedures in place to assist operational nurse managers in managing staffing levels on a daily basis, including requesting bank and agency and red flag escalation processes. This also included moving staff across the sites to ensure that the balance between substantive and temporary staffing was maintained.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers. There was a minimum of two registered children’s nurses on duty at all times on ward 4A and normally a total of three registered nurses during the day. The most senior children’s nurse on duty out of hours was generally a band six paediatric nurse, although staff said they were able to contact the ward sister or matron out of hours. The Royal college of Nursing guidance on defining staffing levels for children and young people’s services states: there should be access to a senior nurse for advice at all times throughout the 24-hour period. In defining the term senior nurse, they state that in addition to the band seven ward sister, a competent experienced band 6 is required throughout the 24 hours periods to provide the necessary support to the nursing team. The children’s ward therefore met this guidance. At least one nurse per shift in each clinical area was trained in advanced or European paediatric life support.

Staffing levels for the neonatal unit complied with BAPM standards. Staff said they normally met the core staffing levels and when they had a shortfall they tried to find a replacement.
Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff told us their permanent staff were often able to accommodate additional hours or move their shifts and when necessary staff from Lincoln County hospital were asked to help. In most cases, it was possible to cover the shift in this way. Otherwise agency nurses could be obtained.

The children’s ward used two regular agency nurses to cover night shifts due to staff vacancies. The same staff had been working in the service for approximately a year.

Managers made sure all bank and agency staff had a full induction and understood the service. Staff used a checklist to ensure agency staff were given a full orientation to the service. A ward sister said agency staff also completed the competency package.

**Medical staffing**

The service did not have enough substantive medical staff with the right qualifications, skills, training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment. They achieved safe care through high use of agency/locum staff although the situation was fragile. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep children and young people safe at the time of our inspection. This was achieved through the use of agency/locum staff.

The agreed consultant establishment was eight whole time equivalents for the Pilgrim hospital. At the time of the inspection, there were four substantive consultants in post and three long term agency/locum consultants. Consultants had a one in seven on call rota.

There were significant shortfalls in the number of middle grade doctors employed and the trust used locum tier one and two doctors to fill gaps in the rota. Some of the locums were long term and staff told us they had a good level of skills. A member of staff said, “We have had some very good locums here, with good knowledge and some have been here for over a year; they don’t let you down.” Middle grade doctors told us they received a good level of support from the consultants. However, some doctors described issues with scheduling of rotas, which made the rota difficult and, in their words, “Onerous.”

Medical staff told us the situation was ‘fragile’ and the information we gained during the inspection supported this. We were made aware of some resignations at middle grade and consultant level, some of which were due to career development.

**Pilgrim Hospital**

Pilgrim Hospital reported the following WTE medical staff numbers for the periods below for children’s services.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>April 2017 to March 2018</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Community paediatrics</td>
<td>5.0</td>
<td>4.4</td>
</tr>
<tr>
<td>Paediatrics inpatients</td>
<td>12.3</td>
<td>19.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17.3</strong></td>
<td><strong>23.4</strong></td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, the medical staffing rate within children’s services at Pilgrim Hospital was 73.9%. This was higher than the rate of 62.7% in the more recent period from April 2018 to February 2019.

Fill rates of more than 100% indicate there were more WTE in post than originally planned.

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

**Vacancy rates**
The service had high vacancy rates for medical staff.

### Pilgrim Hospital

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics inpatients</td>
<td>38.8%</td>
</tr>
<tr>
<td>Community paediatrics</td>
<td>22.3%</td>
</tr>
</tbody>
</table>

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

The trust was in the process of recruiting new consultants and senior managers told us they had interview dates arranged and five consultants had been shortlisted for interview. They were also exploring alternative ways of recruiting, including overseas recruitment. The trust was using an agency to recruit to middle grade posts and were discussing the possibility of increasing the number of trainees with the deanery. They were recruiting and training advanced nurse practitioners to support the middle grade doctors.

### Turnover rates

The service had high turnover rates for medical staff, however, the low number of medical staff employed in the service, impacted on the percentage turnover.

### Pilgrim Hospital

Only one ward had turnover recorded in Pilgrim Hospital from April 2018 to March 2019.

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics inpatients</td>
<td>45.8%</td>
</tr>
</tbody>
</table>

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

### Sickness rates

Sickness rates for medical staff were low.

### Trust level

From April 2018 to March 2019, the trust reported a sickness rate of 1.7% for medical staff in children services. This was lower than the trust target of 4.5%.

- Lincoln County Hospital children services department: 2.6%
- Pilgrim Hospital children services department: 0.4%

A breakdown of sickness rates by ward for each site is below:

### Pilgrim Hospital name

<table>
<thead>
<tr>
<th>Ward / team name</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community paediatrics</td>
<td>0.7%</td>
</tr>
<tr>
<td>Paediatrics inpatients</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

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

### Bank and locum staff usage
The service had high rates of bank and locum staff used on the wards, however, this was mitigated by the use of long term locum staff.

Please note that the trust confirmed that they were unable to provide accurate establishment hours by department and location in all cases. Therefore, we have not calculated the proportion of hours filled by bank and locum staff or left unfilled as this may be misleading.

**Trust level**

The table below shows the number of medical hours in children’s services at site level from April 2018 to February 2019 that were covered by bank and locum staff or left unfilled.

Over this time period, 7,535 hours were filled by bank staff and 23,254 hours were covered by locum staff to cover sickness, absence or vacancy for medical staff. The trust was unable to fill 2,846 of the available hours with either bank or locum staff.

<table>
<thead>
<tr>
<th>Site name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank usage</td>
</tr>
<tr>
<td>Grantham and District Hospital</td>
<td>30</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>3,720</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>3,785</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,535</strong></td>
</tr>
</tbody>
</table>

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

2,846 of the available hours with either bank or locum staff.

**Staffing skill mix**

In January 2019, 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 52 whole time equivalent staff working in services for children and young people 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>33%</td>
<td>43%</td>
</tr>
</tbody>
</table>
Managers could mostly access locums when they needed additional medical staff. The service had been successful in retaining a number of long term locums and they were very knowledgeable about the service.

Managers made sure locums had a full induction to the service before they started work. Locum staff and longer term medical staff told us they received a comprehensive induction and they received a good level of support from colleagues and consultants.

**Records**

**Staff kept detailed records of children and young peoples’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

Patient notes were comprehensive and all staff could access them easily. Information needed to deliver safe care and treatment was available to staff in a timely way. The majority of patient records were paper based, although there was electronic recording of vital signs observations and PEWS scores and some theatre systems were electronic.

We reviewed eight patient records. Entries were legible, dated, timed and signed and the designation of the person making the entry was usually recorded. An initial assessment was completed, with past medical history and details of the presenting complaint. We found entries were clear, there was a plan for the patient and daily updates were recorded. All nursing assessments were completed fully and nursing notes were comprehensive. When children and young people had surgical procedures, the anaesthetic and operation notes were completed, along with a recovery record and post-operative interventions.

In the children’s outpatient department, patient records were stored behind the nurses’ station that was manned constantly. Doctors returned the notes to the nursing staff following the patient’s attendance.

When children and young people transferred to a new team, there were no delays in staff accessing their records. We did not see any examples of transfers to other internal or external providers except GPs to inform the inspection.

On discharge from hospital, a summary of the admission and treatment provided should be sent to the patient’s GP. The trust used an electronic system to produce the discharge summary. A copy of the discharge summary was sent electronically to the patient’s GP and the patient was given a copy to take home. Staff told us discharge summaries were normally produced before the patient left hospital, however there were times when the discharge summary was delayed and sent up to two days after discharge.
Records were stored securely. Patients records were stored on the wards in locked trolleys. Staff used a keypad lock to access the notes and this was used effectively by staff.

The children’s ward had electronic white boards to display the beds in use and key details about the patient. They did not provide any patient details and therefore maintained confidentiality.

**Medicines**

**The service mostly used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Suitable arrangements were in place for the safe management of medicines as outlined in the trust's medicines policy. This included obtaining, prescribing, recording, security, dispensing, safe administration and disposal.

We checked eight medicines administration charts. We found them to be legible, signed by the prescriber, and the bleep number or role was recorded.

Patients/parents were able to self-administer medications following assessment in line with trust policy.

Staff reviewed children and young people’s medicines regularly and provided specific advice to children, young people and their families about their medicines. When antibiotics are prescribed, an indication for the antibiotics and a review date should be recorded, to ensure antibiotics are not continued for any longer than is necessary. We saw evidence of antibiotic review on the medicines administration charts and the indication for the antibiotic was recorded.

There was a daily service from the pharmacy team to the wards and staff told us the pharmacy team would talk to patients / carers about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. We saw evidence of appropriate storage of medicines, however, we saw one occasion where a medicine with a short expiry date when opened was not annotated accordingly. Medicines within the wards and theatres were stored safely behind locked doors or cupboards and were only accessible to appropriate staff. Controlled drugs (CDs) (a medicine that is controlled under the Misuse of Drugs legislation 2001), were stored appropriately in a locked cupboard and the keys held separately from the main keys. We checked four controlled drugs and the controlled drugs register and found the required records were correctly maintained. Staff carried out and recorded checks of controlled drugs daily. All CD records checked were accurate and up to date. Staff told us pharmacy staff checked all medicines weekly.

Medicines that required refrigeration were kept at the correct temperature and staff checked and recorded the fridge temperatures daily. However, point temperatures only were being recorded for the medicine fridges on each ward. Staff did not record minimum and maximum temperatures, which meant they could not be sure the temperatures remained consistently within acceptable limits. This did not follow the trust policy which stated the maximum and minimum temperatures should be recorded and reset daily. The temperature of the rooms used to store medicines were not recorded in line with good practice.

Intravenous fluids were stored safely and those we checked were within their use by date.

Blank prescription forms were stored securely

Staff followed current national practice to check children and young people had the correct medicines. There was a pharmacy service to wards daily Monday to Friday and their review of patient’s medicines was evidenced on the charts. Children’s and young people’s weight was recorded on their medicines administration charts, to ensure the prescriber was able to prescribe the correct amount of each medicine, when the dose was prescribed according to weight. Allergies
were also documented on the medicines charts to avoid the prescription and administration of medicines the child or young person was allergic to.

We observed the administration of medicines and saw nurses carried out the appropriate checks to ensure the medicines were administered as prescribed. Children told us staff checked their name and wrist band prior to administering medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Whilst staff were aware of safety alerts and recalls we did not see an effective feedback mechanism such that the trust was assured appropriate actions had been taken.

Good examples of shared learning across the sites was evidenced. Staff told us they received updates from pharmacy about safety alerts and incidents to ensure they were aware of any changes to medicines practices.

Penicillin based medicines were clearly labelled and stored separately from other antibiotics. Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. No examples of medicines being used to control behaviour were seen. Ward 4A was a short stay unit and therefore they did not normally have regular medicines. A paediatric pharmacist checked all drug charts to review prescribed medicines and was able to raise concerns.

**Incidents**

The service did not always manage patient safety incidents well. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service, as systems for sharing learning were not robust.

However, staff recognised incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Nursing and medical staff we spoke with, were aware of what an incident was, and the importance of reporting incidents. The trust used an electronic incident reporting system and staff were confident in using it.

Staff reported incidents that they should report. They were able to give us examples of incidents they had reported. They said they reported all stays of over 12 hours on the incident recording system, for example. One member of staff told us of an incident they had reported in relation to a missed medicine.

**Never Events**

The service had no never events on either ward 4A or the neonatal unit.

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

From March 2018 to February 2019, the trust reported no never events for services to children and young people.

*(Source: Strategic Executive Information System (STEIS))*

Managers shared learning with their staff about never events that happened elsewhere.
A member of staff in theatres told us of learning from two never events that occurred at another hospital including an issue with a retained swab and the emphasis following this on the checking of all items used.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in services for children and young people which met the reporting criteria set by NHS England from March 2018 to February 2019.

Breakdowns of the serious incidents by type and trust site are shown in the tables below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/obstetric incident: baby only (this include foetus, neonate and infant)</td>
<td>2</td>
<td>66.7%</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Trust-wide</strong></td>
<td>3</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>No. of serious incidents</th>
<th>% of serious incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>2</td>
<td>66.7%</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Trust-wide</strong></td>
<td>3</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Pilgrim Hospital**

In accordance with the Serious Incident Framework 2015, Pilgrim Hospital reported one serious incident (SIs) in services for children and young people which met the reporting criteria set by NHS England from March 2018 to February 2019. This was classified as other maternity/obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant).

*Source: Strategic Executive Information System (STEIS)*

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. Staff we spoke with, were aware of the duty of candour legislation and the importance of being open and transparent with patients and families when mistakes were made. A band six nurse said, “We would ensure the patient was safe and would tell the parents as soon as possible and apologise. We would document the issue and the ward manager and the doctors would take it forward.” They went on to say the consultants were always very willing to speak with parents and full explanations were given to them. The trust provided a copy of a letter sent to parents following an incident, which provided an explanation of the investigation process, a full apology and a commitment to provide the parents with a copy of the final investigation report.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. At our previous inspection in March 2018, we told the trust they must ensure there was a robust system for learning from incidents. Whilst at this inspection we found there was an improvement in learning from incidents, we were not confident that there was a robust system in place.

A member of staff said when they reported an incident, they received an email reply with learning outcomes and immediate changes. Some staff described receiving feedback of learning from incidents following the completion of an investigation. However, a doctor told us the dissemination
of learning from incidents was the responsibility of the investigator and was not systematic. Learning might be shared at teaching sessions or at handover. Another doctor told us they did not receive any feedback on learning from incidents. Ward staff told us they received feedback on incidents at ward meetings; however, this was usually in relation to incidents that had happened in their area, rather than trust wide learning.

Theatre staff told us communication had improved over the last 12 months and there was more pan-trust sharing of practice and knowledge.

Staff met to discuss the feedback and look at improvements to children and young people’s care. Nursing staff said they had staff meetings and discussed how care could be improved at these meetings,

There was evidence that changes had been made as a result of feedback. A nurse on the neonatal unit described how they had changed the place they kept medicines administration charts, as a result of a missed medicine and how the responsibility for ensuring medicines were given on time, had been reviewed and changed. A consultant also described how the prescribing of gentamicin (an antibiotic) had been discussed and reviewed following an incident.

Managers investigated incidents thoroughly however, the resulting action plans did not always adequately address all the issues raised. Children, young people and their families were involved in these investigations. Managers told us the most appropriate person to investigate the incident was identified and when serious incidents occurred a route cause analysis was undertaken. We reviewed a route cause analysis for a serious incident in the neonatal unit and found a detailed time line of events was prepared and there was a full discussion and review of each action taken in comparison to local and national guidance. All aspects of care where there was a deviation from best practice were identified and an action place was developed with responsibilities clearly identified. However, we also found that although the correct use of the newborn early warning score was listed as an issue, there was no action to provide re-training on the use of the score, or to complete a further audit to check whether the score was generally being used correctly. There was evidence the parents were involved in contributing relevant facts to the investigation and were fully informed of the investigation and it’s outcomes.

Managers debriefed and supported staff after any serious incident. A member of staff spoke about the availability of support and debriefing they received following a safeguarding incident.

Managers acted in response to patient safety alerts within the deadline and monitored changes.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

Safety thermometer data wasn’t displayed on wards for staff, children, young people and their families to see. However, the harms measured had limited applicability to the service due to the short stay nature of the unit.

The safety thermometer data showed the services achieved over 95% harm free care for the last 12 months.

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.
Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from March 2018 to March 2019 for children’s services.

(Source: NHS Digital)

Staff used the safety data to further improve services. Staff told us they monitored a range of safety indicators such as the use of PEWS, access indicators and peripheral cannula care. They told us of the action to further improve the identification and management of sepsis for example.

Is the service effective?

Evidence-based care and treatment

There was a risk the service did not provide care and treatment based on national guidance and best practice. Managers did not check to make sure staff followed guidance.

However, staff protected the rights of patients subject to the Mental Health Act 1983.

At our last inspection in March 2018 we asked the trust to ensure care and treatment is delivered in line with evidence based practice. At this inspection, we did not receive assurance that the requirement had been fully complied with.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. There was a risk that staff might follow guidance that was out of date and no longer considered best practice. Staff had access to trust policies and practice guidelines on the trust intranet and were able to access them readily. However, most of those we checked were past the date when a review was due. We identified nine policies and guidelines which were past their review date, including two safeguarding policies and clinical guidelines for the management of newly diagnosed diabetes, urinary tract infection and nasogastric feeding. In addition, the standard operating procedure for the monitoring of all fridges and freezers used for the storage of medicines expired in 2017.

The divisional team were aware of the issue and a large volume of expired guidelines was listed as a risk on the divisional risk register. Actions to reduce the risk were, to maintain monthly guideline meetings and to source administrative support. However, the outlined actions did not provide us with assurance that the issue would be resolved in the short term and there was no indication that a review of the guidelines would be undertaken to identify those at highest risk of providing out of date guidance. We noted there had been a discussion at the neonatal clinical governance meeting as to whether to remove all out of date guidelines or to place a warning on them to state the guidance might be out of date.

During the inspection, we found staff referred to trust guidelines as a first step and if they did not provide the information required, or staff felt the guidance had been superseded, they referred to the guidelines of tertiary referral centres in the locality. In this way, patients received care based on good practice guidance and risks were mitigated. However, this approach could lead to inconsistencies in the management of patients, as different staff might not refer to the same tertiary centre’s guidance for the same issue. There was no formal guidance for staff as to the guidance that should be used, when trust guidance was insufficient or not available.

Staff knew how to access national best practice guidelines from bodies such as the national institute for health and care excellence (NICE). However, we were not assured that staff followed the guidance consistently. The trust provided limited evidence of audits to assess compliance with national guidelines. We were provided with details of two audits within the trust, to assess
compliance with NICE guidance. However, they were not undertaken at the Pilgrim hospital. Both showed compliance with some aspects of the guidance and identified areas for improvement.

In 2017, the service developed a care pathway for the assessment and diagnosis of children with suspected autistic spectrum disorder. This helped to ensure a consistent and systematic assessment process. It took a multi-disciplinary approach and was developed in collaboration with the community paediatric service and speech and language therapists. An audit was completed to assess the success of the pathway and compliance with it and was aligned with NICE guidance. The audit demonstrated improvements in follow up, provision of autistic spectrum disorder packs, social and communication assessments and a multi-disciplinary approach to diagnosis.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff were aware of the requirements of the Mental Health Act and their responsibilities.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. (AMSAT) We attended a morning handover meeting and found staff took a holistic approach to the discussion of babies, children and young people and their family, including discussion of their psychological and emotional needs.

**Nutrition and hydration**

**Staff did not always follow national guidelines to make sure patients fasting before surgery were not without food for long periods.**

However, **staff gave patients enough food and drink to meet their needs and improve their health.**

Staff made sure children, young people and their families had enough to eat and drink. Young people and parents of younger children and babies said they were offered a wide range of food and drink appropriate to their needs. There was an infant feeding lead on the neonatal unit and parents commented there were a range of baby milks available on the children’s ward, to enable them to provide the same milk as they used at home. There were facilities for breast feeding within the service.

Staff fully and accurately completed children and young peoples’ fluid and nutrition charts where needed. We observed that when staff needed to monitor children’s food and fluid intake, they kept good records of this. Fluid totals were calculated every 24 hours.

Staff did not use a nationally recognised screening tool to monitor children and young people at risk of malnutrition. Staff assessed children’s nutritional needs on admission to hospital. They did not use a nationally recognised screening tool; however, patients were normally at low nutritional risk and most patients stayed on the unit for less than 12 hours.

Specialist support from staff such as dieticians was available for children and young people who needed it. The paediatric dietitian was based at Lincoln County hospital and could be contacted for advice and assessment when required.

Patients waiting to have surgery were sometimes left nil by mouth for long periods. Children and young people admitted for surgery, were given clear instructions about when they could last eat and drink prior to surgery and the guidance followed the trust policy and national guidance. However, when children were delayed in going to theatre, staff were not always informed and told the child could have an additional drink when this was safe. For example, a child was admitted at 11am; they had been told not to eat after 7.30am and not to drink from 10.30am. However, they were second on the afternoon list and therefore could have been allowed a drink after they arrived at 11am. The first case was delayed and the child did not go into the anaesthetic room until 4.30pm therefore the child was without drinks for an extended period. This is not in line with best practice guidance.

**Pain relief**
Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young peoples’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. The bedside folders containing children’s observation charts on the children’s ward, contained a laminated sheet with a visual tool for children to assess their pain. Staff also used a visual analogue scale for older children. In the neonatal unit, staff used a recognised behavioural assessment tool to assess pain in babies in the unit.

Children and young people received pain relief soon after requesting it. Parents told us staff checked whether their child had any pain and administered pain relief promptly when they needed it.

Staff prescribed, administered and recorded all pain relief accurately. We noted that when children returned from the operating theatre following surgery, medical staff had prescribed pain relieving medicines and anti-sickness medicines. Eight medicines charts we reviewed, showed that pain relieving medicines were prescribed and when medicines were administered, the medicines chart was completed accurately.

**Patient outcomes**

Staff did not always monitor the effectiveness of care and treatment. They did not consistently use findings from monitoring to make improvements and achieve good outcomes for patients.

However, the service had gained stage one accreditation in the UNICEF Baby Friendly accreditation scheme.

The service participated in all the relevant national clinical audits. The service did not always perform well in national clinical outcome audits; however, managers used the results to improve services further.

The service participated in the paediatric diabetes audit. However, did not perform well in the completion of seven key health checks for young people over 12 years of age.

**Paediatric diabetes audit**

**Pilgrim Hospital**

The table below summarises Pilgrim Hospital’s performance in the 2017 National Paediatric Diabetes Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion rate for key health checks for patients aged 12+ (There are seven key care processes recommended by NICE for patients with Type 1 diabetes that should be performed at least annually)</td>
<td>58.3%</td>
<td>Negative outlier</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted mean HbA1c (HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled. This measure is provided for benchmarking against other providers during an audit year)</td>
<td>64.8</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Median HbA1c (This measure is provided to give an indicator of how performance has changed between the</td>
<td>61.0</td>
<td>Clinically significant improvement</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
previous and latest audit reports. A change of 1 mmol/mol is deemed to be clinically significant.

(Source: National Paediatric Diabetes Audit)

Members of the diabetes team said there was a trust wide action plan to improve following the results of the audit. They told us a business case had been submitted to obtain the resources 
required to provide point of care testing for patients and a database to monitor care and treatment. There were some ongoing issues with dietetic support due to staff vacancies, although they told us they received excellent support from a psychologist. The trust provided a copy of the action plan with progress against the individual areas for improvement and which confirmed the information we were given.

The trust provided details of their performance in the national diabetes transition audit which compared results for those young people transitioning between children’s and adult services. This showed similar results to the national paediatric diabetes audit reported above.

National Neonatal Audit Programme

Pilgrim Hospital

The table below summarises Pilgrim Hospital’s performance in the 2018 National Neonatal Audit Programme against measures related to paediatric care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do all babies &lt;32 weeks gestation have a temperature taken within an hour of admission that is 36.5ºC-37.5ºC? <em>(Low body temperature on admission is associated with increased complications, such as hypoglycaemia, jaundice and respiratory distress, and death in pre-term infants)</em></td>
<td>61.2%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission? <em>(Timely consultation with parents/carers is crucial to allaying fear and anxiety and improves the parent/carer experience)</em></td>
<td>98.9%</td>
<td>Positive Outlier</td>
<td>✗</td>
</tr>
<tr>
<td>Do all babies &lt;1,501g or a gestational age of &lt; 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP) <em>(ROP is a preventable cause of blindness in pre-term infants provided it is detected and treated in a timely way)</em></td>
<td>96.6%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Do all babies with a gestation at birth &lt;30 weeks receive a documented follow-up at two years gestationally corrected age? <em>(It is important that the development of pre-term babies is monitored by a paediatrician or neonatologist after discharge from the neonatal unit)</em></td>
<td>56.5%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
</tbody>
</table>

(Source: National Neonatal Audit Programme)
The trust was within the expected range for most elements of the audit and performed well in relation to consultation with patients by a senior member of the neonatal team within 24 hours. The trust did not provide any details of an action plan for further improvement.

The trust provided data to demonstrate their involvement in the national Epilepsy 12 organisational audit in 2018. This showed there was no defined epilepsy lead for the trust, no identified consultant with a specialist interest in epilepsy and no input from a specialist epilepsy nurse. There was comprehensive care planning for children and young people and screening for other conditions such as ADHD. There was a referral pathway for transfer to adult services but no transition clinics.

The trust also provided information on a quality improvement project to assess compliance with NICE guideline (CG137) on the investigation and management of childhood epilepsy. The results were reported in May 2019 and identified some areas of poor compliance. Actions from the audit included a recommendation that an integrated care pathway was developed.

The trust did not report any participation in formal surgical site infection audits in paediatrics prior to 2019 and participation in these audits was voluntary. However, they said they had registered for the national surgical site infection paediatric audit from May to September 2019 and they told us there was an active GIRFT surgical site infection audit. Getting It Right First Time (GIRFT) is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. (Main PIR: Surgery CYP tab)

The service was accredited by UNICEF baby friendly accreditation scheme at stage one and was preparing to apply for stage two accreditation. The neonatal unit were working towards the Baby Bliss charter standards. They had completed a self-assessment in relation to the standards and had received feedback about additional evidence required.

**Emergency readmission rates within two days of discharge**

From December 2017 to November 2018 there were no emergency readmissions after elective admission at this trust among patients in the under 1 age group and insufficient admissions for the one to 17 age group to produce any data table for this trust.

The service had a lower than expected risk of readmission for non-elective care than the England average. The data in the following two tables shows emergency readmissions within two days of discharge following emergency admission. From December 2017 to November 2018, the trust’s readmission rate for patients aged under one years old admitted to paediatrics was the same as the England average.

Over the same time period, there was a slightly lower percentage of patients aged one to 17 years old readmitted following an emergency admission to paediatrics compared to the England average. No other speciality at the trust had six or more readmissions.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>3.6%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Discharges (n)</td>
<td>1,942</td>
<td></td>
</tr>
<tr>
<td>Readmissions (n)</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>Readmission rate</td>
<td></td>
<td></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 (December 2017 to November 2018)

<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>2.6%</td>
<td>3,986</td>
</tr>
</tbody>
</table>

No other specialty at this trust had six or more readmissions.

Notes: These tables show the three treatment specialties at the trust with the highest volumes of readmissions; only those specialties where the trust had 6 or more readmissions recorded are shown in the tables.

(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 December 2017 to November 2018 the trust performed better than the England average for the percentage of patients under the age of one who had multiple readmissions for asthma.

The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma and worse than the England average for multiple readmissions for epilepsy.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 year and 1 to 17 years). (January to December 2018)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>0.0%</td>
<td>*</td>
</tr>
<tr>
<td>1 to 17</td>
<td>13.0%</td>
<td>108</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>*</td>
<td>49</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>8</td>
</tr>
<tr>
<td>1 to 17</td>
<td>30.8%</td>
<td>39</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with "*". The "-" (a hyphen) in the table indicates that there were no admissions for these long term condition or age groups.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Managers did not carry out a comprehensive audit programme at the Pilgrim hospital. Following our last inspection in March 2018 we asked the trust to ensure there was a robust audit plan which is carried out to ensure evidence-based care is applied. At this inspection, the requirement had not been met.

Only five audits at the Pilgrim hospital were registered with the trust clinical audit department during 2018/2019, and the results and recommendations were available for only two of these.
The trust provided a list of 23 audits registered during 2018/2019 for children's and young people's services across all of the sites. Of those registered, only five were identified as having been completed and four of these were completed by junior doctors. However, a total of 11 audits had some results identified.

The two audits with available results at the Pilgrim hospital were as follows:

- A review of compliance with local best practice guidance on cranial ultrasound in neonates. This showed good compliance for babies born at the Pilgrim hospital, however, improvements were needed for babies transferred from other units due to poor documentation in the Badger database (a national neonatal database that provides a single record of care for all babies within neonatal services). An action plan was developed to address the issues and this included discussing the findings at the neonatal network.
- Use of echocardiography for diagnosis of congenital heart disease in new-born babies referred for scan in 2018. An audit was registered for each hospital site. Audit results from the Pilgrim hospital showed some good practice and areas for improvement. It recommended the development of agreed criteria for assessment of babies with any of the risk factors and a standardised method for referrals. It was reported in May 2019 therefore, the timescale for actions had not been reached at the time of this report.

Other audits were reported at Lincoln County hospital and for paediatric community services. There was potential for learning in relation to practice at the Pilgrim hospital. However, it was unclear how widely the results had been disseminated. These included:

- An audit to review the identification and treatment of early neonatal sepsis completed at Lincoln County hospital in November and December 2018. An action plan was developed, but it was unclear as to dissemination across the trust.
- An audit to review compliance with NICE guidance (NG9) on the acute assessment and management of bronchiolitis. It found there was good history taking, and cohorting of children in busy winter periods. However, it also found variations in managing children, which were not evidence based and completion of some investigations which were not clinically indicated. The findings were presented and an action plan developed, however, there was no information about progress with the actions identified in the plan.

We identified one audit that was shared more widely. This looked at the use of high flow nasal cannula oxygen therapy in bronchiolitis. The audit showed good practice in some areas and two areas for improvement. The audit findings were presented at the East Midlands paediatric respiratory society study day in January 2019.

A paediatric prescription audit was completed at Lincoln County hospital and reported in December 2018. This found 100% compliance in the accurate documentation of drug name, does, route and frequency and 100% review of antibiotics and medicines prescribed to be given only when required. It showed poor documentation of the prescriber's name and signature and 70% compliance with clear demographic details. As a result, a summary of the Royal College of Paediatrics and Child Health prescription training was to be available to all new doctors at induction. The actions from this audit were therefore applied to doctors at the Pilgrim hospital.

Managers used information from the audits to improve care and treatment. As reported against each of the national and local audits above, when audits were undertaken, the results of the audits were mostly discussed and in some cases actions were identified and completed to improve care and treatment. We saw evidence of the promotion of sepsis and the trust provided information about the additional training and support provided to improve the identification and timely management of sepsis.

There were engagement meetings, although little evidence of follow-up of audit outliers. The information provided by the trust showed that some findings from audits were discussed, in some case using the audits to inform teaching sessions for junior staff. However, follow up of audit outliers was not always undertaken.
Managers did not always share and make sure staff understood information from the audits. There was no identified audit clinical lead for children’s and young people’s services and the infrastructure to ensure the results and action plans from audits was shared widely, were understood and influenced practice was not in place.

Improvement was not always checked and monitored. Whilst there was some evidence of the ongoing monitoring of some quality indicators such as the identification of the deteriorating patient, sepsis and hand hygiene to monitor improvement, there was little evidence of monitoring and checking that action plans from national audits were being progressed.

**Competent staff**

The service made sure staff were competent for their roles. However, managers did not always appraise staff’s work performance and hold supervision meetings with them to provide support and development.

There were not enough clinical educators to support staff learning and development. The clinical educator role for children’s and young people’s services had been vacant for over two years and this had limited the amount of support available for staff to develop their skills in clinical practice. However, other opportunities for staff learning and development were provided.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and families. Nursing staff completed competencies to ensure they developed the skills and knowledge required for their area. We observed staff working competently and confidently in their areas during the inspection; doctors were complementary about the skills of the nursing staff and vice versa. However, there were no registered children’s nurses working in the operating theatres and no regular oversight of care in theatres by a registered children’s nurse.

There was always at least one registered children’s nurse on duty with paediatric advanced life support or European paediatric life support training. This was in line with national guidance.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with were positive about their induction and told us they felt well supported.

**Appraisal rates**

Managers did not always support nursing staff to develop through yearly, constructive appraisals of their work. However, 100% of medical staff had an annual appraisal.

**Pilgrim Hospital**

From April 2018 to February 2019, 80.2% of staff within children’s services at Pilgrim hospital received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>13</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>29</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>27</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Appraisal rates information we were shown during the inspection, showed significant improvement for nursing staff had occurred more recently. Current compliance rates for registered nurses was
88% and for support staff was 100% on the neonatal unit. On ward 4A, a senior nurse told us there were seven outstanding appraisals due to the loss of two band 6 staff who had responsibility for some of the appraisals. However, two new band six nurses had been appointed and dates had been booked for the outstanding appraisals.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Staff told us they had regular team meetings and the minutes of the meetings were emailed to staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Trainee medical staff said they had allocated supervisors and were able to attend regular teaching. They said there were lectures, journal clubs or case discussions three times a week. Nursing staff had access to training provided by the local children’s and neonatal intensive care decision support and transfer services. They held airway days, breathing days and circulation days for example along with simulation days. Staff were encouraged to attend these.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. A nurse identified they were experiencing less exposure to critically ill and high dependency patients such as those with tracheostomies. As a result, steps were being taken to address these issues and they were to be given the opportunity to spend some time with the community children’s nurses to get hands on experience. Another nurse told us they had discussed access to training on their appraisal and they were encouraged to develop an area of interest or expertise and training opportunities for this were explored.

Managers made sure staff received any specialist training for their role. Nursing staff in the neonatal unit had the opportunity to gain their ‘qualified in speciality’ qualification, equipping them with the knowledge and skills to provide neonatal intensive care. Two band five nurses were in the process of completing the qualification at the time of the inspection. Staff on the paediatric ward had undertaken training in mental health issues to enable them to undertake initial risk assessments and provide ongoing care for children and young people with mental health problems. They also had access to study days in caring for high dependency patients.

Managers identified poor staff performance promptly and supported staff to improve. Managers discussed how they provided regular clinical oversight within the wards and departments and how they provided support to staff when they identified an issue.

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Nurses from the children’s ward and the neonatal unit attended the morning medical handover and contributed appropriately.

**CQC Children and Young People’s Survey 2016 – Q23**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.9 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)

Staff worked across health care disciplines and with other agencies when required to care for children, young people and families. There were multi-disciplinary clinics for children with long term conditions such as diabetes and cystic fibrosis. These brought together the relevant
specialists to ensure children and young people were able to access all the professionals at one visit. The service worked with tertiary centres to jointly manage the care of children with complex conditions. For example, joint clinics were held with a nephrologist from one tertiary centre and an endocrinologist from another tertiary centre.

A play specialist was available on the children’s ward; however, this wasn’t a full time post and due to the short stay of most children, some children did not have access to them. The senior management team told us the workforce review being undertaken including the provision of play specialists and they planned to increase the provision.

There was no play specialist input into the children’s outpatient department. Some of the healthcare support workers were qualified nursery nurses, however, they were not able to provide play activities for children waiting for the clinic due to their responsibilities for the running of the clinics.

Staff communicated with GPs when patients were discharged from hospital through an electronic discharge summary. This facilitated timely communication, although we were told there had been some problems with delays to summaries. This had been discussed with consultants and they reminded junior doctors of the importance of prompt communication with GPs.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. (AMSAT) The trust stated in their provider information return that the child and adolescent mental health service provided by the mental health trust provided 24 hour a day, seven day a week access. Staff on the children’s ward said they could contact the service for advice, however, the team would not normally come to assess a patient until they had completed their medical treatment and were considered to be medically fit. When a successful referral was made, a member of the team visited to assess the patient within 24 hours.

**Seven-day services**

**Key services were not always available seven days a week to support timely patient care.**

Consultants led daily ward rounds on all wards, including weekends. Children and young people were reviewed by consultants depending on the care pathway. Consultants were on site until 10pm each evening and provided on call cover out of hours. Staff told us they had good access to consultants who were supportive and willing to attend whenever they were required.

Staff could call for support from doctors and some other disciplines, including mental health. services 24 hours a day, seven days a week. However, access to some diagnostic tests was not always available on site. Staff told us doctors were available and responded promptly when required. There was access to a paediatric dietician based at Lincoln County hospital. Pharmacy was open from 9am to 5.15pm Monday to Friday and from 9.30am to 12.30pm Saturday and Sunday. There was access to an on-call pharmacist outside these hours.

However, during the inspection we were told of a child that was transferred to Lincoln County hospital due to lack of resources at the Pilgrim hospital to undertake an urgent ECG (heart check) at the Pilgrim hospital that day. There were some restrictions in the availability of diagnostic tests and imaging particularly out of hours. The absence of an EEG (brain activity monitoring) facility at the Pilgrim Hospital was identified on the risk register. Medical staff told us there were some delays in getting results for a test that was important for diagnosis of infective status and there were some restrictions on the availability of diagnostic and interventional radiology out of hours.

**Health promotion**

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. A range of information leaflets and displays were available in all clinical areas on a variety of topics such as healthy eating and treatment of common conditions such as head lice and prevention of flu. In addition, there was information in the children’s outpatient clinics on the
availability of services such as opticians and a dental service for children and young people with additional needs. There were also leaflets signposting people with diabetes to an epilepsy charity that provided courses for people with epilepsy to help them better manage their condition and well-being.

The neonatal unit had a breast feeding key worker and told us advice started on labour ward with skin to skin contact and staff offered assistance and information on the benefits of breast feeding, without pressuring women in any way.

Staff assessed each child and young person’s health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, lots of information was provided to children and young people about healthy eating, the benefits of exercise and the prevention of the complications of diabetes.

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

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff we spoke with, were aware of the requirements for obtaining consent for treatments and procedures and the Gillick and Fraser competencies, which apply to assessing the competence of children and young people to consent to treatment.

Staff made sure children, young people and families consented to treatment based on all the information available. Parents said they were provided with in-depth information and explanations about the treatments proposed and the risks and benefits. They were also given written information to take away with them.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions. Medical staff were aware of the Mental Capacity Act (2005) and the implications for young people between 16 and 18 years of age. They explained how they involved the child, people close to the child and other professionals in making a best interest decision, when children, young people and their families could not give consent.

Staff clearly recorded consent in the children and young peoples’ records. We reviewed the consent forms for five children and young people undergoing a surgical procedure and found they were fully completed.

The trust completed an audit of 30 consent forms in paediatric services during 2018/2019 and found improvements in adherence to best practice standards as compared to audits completed in the previous two years. There was 100% compliance in 21 of the 29 standards and improvements in most others. An action plan to bring about further improvement was developed and was underway.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

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

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The MCA training delivered covers all levels required and DoLS training is included in the same session so is not reported separately.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
Pilgrim Hospital

A breakdown of compliance for MCA/DoLS training courses at Pilgrim Hospital for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>38</td>
<td>43</td>
<td>88.4%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services at Pilgrim Hospital the target was not met for the MCA/DoLS training module for which qualified nursing staff were eligible, although the completion rate was above 85%.

A breakdown of compliance for safeguarding training courses at Pilgrim Hospital for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As of February 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>12</td>
<td>17</td>
<td>70.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services at Pilgrim Hospital the target was not met for the MCA/DoLS training module for which medical staff were eligible.

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

Other CQC survey data

CQC Children and Young People’s Survey 2016 Data

The trust performed about the same as other trusts for four of the five questions relating to effectiveness in the CQC Children and Young People’s Survey 2016. No score was provided for question 54.

CQC Children’s Survey questions, effective domain, United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<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>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>19</td>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>33</td>
<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>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>54</td>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 children</td>
<td>No Score</td>
<td>No Score</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age  
0-15 adults = asked of parents and carers of children up to 15 years of age  
8-11 children = asked of children aged from eight to 11 years of age
Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice (AMSAT). Staff told us they worked closely with the children’s and adolescent mental health team and the trust safeguarding team if there were any issues.

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. Parents of children undergoing planned surgery said they had signed the consent form at the outpatient visit and had re-visited it on the day of surgery. This is in line with best practice guidance.

Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children young people and families. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff checking on children’s needs and preferences and considering their privacy. For example, we observed staff spending time with a child and their parents, exploring ways to ease a child’s distress and providing distraction, when there were delays in them going to theatre.

Dignity in care pledges were displayed on the ward and we saw information about the availability of chaperones was displayed in the children’s outpatient department.

Children, young people and their families said staff treated them well and with kindness. Children and their parents commented that staff were friendly and kind, putting them at their ease. A parent said, “All the staff are lovely; they are kind and know how to interact with children.”

Staff followed policy to keep care and treatment confidential. Staff in the children’s outpatient department took care to ensure that when they asked children and parents to confirm their identity, they did this discreetly and away from other people. Staff checked on the relationship between the adult and child before providing any information. All discussions with children and their parents on the ward took place out of the hearing range of other families.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. (AMSAT). We attended a ward round when the care of a young person with mental health needs was discussed. Staff were respectful in their discussions and showed empathy and understanding of the person’s needs.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. English was not the first language of some of the parents of babies and children on the wards. Staff checked carefully with them, to ensure they understood the care plan for their child and their individual preferences. Staff asked about people’s cultural and religious needs to enable them to plan their care accordingly.

Chaplaincy services were available, for spiritual support for all patients, relatives, carers and staff regardless of whether they identified with any religion, belief or none (Main PIR)

The trust performed about the same as other trusts for each of the 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 number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Source: CQC Children and Young People’s Survey 2016, RCPCH)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>0-7 adults</td>
<td>0-15 adults</td>
<td>8-15 children</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------</td>
<td>---------------</td>
</tr>
<tr>
<td>10</td>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>14</td>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>22</td>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42</td>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43</td>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>44</td>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>58</td>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 children</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>64</td>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 children</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>74</td>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 children</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>75</td>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 children</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age  
0-15 adults = asked of parents and carers of children up to 15 years of age  
8-15 children = asked of children aged from eight to 15 years of age  

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

Staff provided emotional support to children, young people and their families to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Parents told us how supportive staff were and how they provided reassurance when they were anxious. On the neonatal unit parents, spoke of the support they received from staff. A thank you card from parents of a baby following discharge said, “Thank you for being a shoulder to cry on when I’ve needed it.”

Staff supported children, young people and families who became distressed in an open environment and helped them maintain their privacy and dignity. (AMSAT) We observed staff offering a side room to a child who was becoming distressed and the opportunity to leave the ward for a while to make them less anxious.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There was a bereavement lead for the neonatal unit and staff spoke with us about how they managed difficult conversations with parents and the support and time they gave them when they were breaking bad news. They had a bereavement box with a variety of clothing and shawls to wrap babies in and the facilities to create mementoes for parents of babies who passed away.

Staff understood the emotional and social impact that a child or young person’s care, treatment or condition had on their, and their family’s wellbeing. There was information on ward 4A and the neonatal unit about support groups for children and parents. For example, information about carers support in the locality was available. A ‘Little Snapps’ (Support Neonates and Parents of Pilgrim Special care) monthly support group was run by an external agency and information was displayed about it. There was also information about children’s centres in Boston.
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.

CQC Children and Young People’s Survey 2016 questions, emotional support, United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29</td>
<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>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>45</td>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>65</td>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 children</td>
<td>9.5</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>67</td>
<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 children</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age
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8-15 children = asked of children aged from eight to 15 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and families understood their care and treatment. A parent said, “We saw a paediatric doctor quickly and they explained everything.” The parent told us they were waiting for some results of tests; however, they were confident staff would speak with them as soon as the results were available. Parents we spoke with knew the plan for their child’s care and treatment and the next steps for them.

Staff talked with children, young people and families in a way they could understand, using communication aids where necessary. Children and young people told us staff explained things to them in ways they could understand and gave them the opportunity to ask questions. A parent also commented on this and said, “We could ask questions and they explained things really well.”

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. We saw there were a variety of ways for children, young people and their families to give feedback and information about these was displayed in the wards and departments. For example, information was displayed on ward 4A about an on line survey “Your experiences matter” and feedback forms were given to parents on the neonatal unit when their baby was discharged.

Staff supported children, young people and families to make informed decisions about their care. Parents of young children admitted for surgery told us they had the opportunity to have a full discussion about their child’s treatment and the possible options for treatment. They told us that by
the time they were asked to sign the consent form they felt they had all the information they needed to make the decision.

A varying proportion of children, young people and families gave feedback about the service in the Friends and Family Test survey. The percentage of children, young people and families giving feedback about the service on the children’s ward was in line with the England average. However, the volume of feedback for the children’s outpatient clinic was low. For example, the results displayed in the department showed there was one response in March 2019 for the children’s clinics. Staff told us the friends and family test surveys were sent out following attendance at clinic by a text messaging system, however, they did not know how this was managed.

The feedback from the Friends and Family Test was positive for all wards. 99% to 100% of children, young people and families recommended ward 4A to their families and friends in 2019. The most recent results for the children’s outpatient was 100%.

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for each of the questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<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>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>12</td>
<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>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>15</td>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>16</td>
<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>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>17</td>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>18</td>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31</td>
<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>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32</td>
<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>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>34</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>39</td>
<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>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41</td>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>59</td>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 children</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>60</td>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 children</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>61</td>
<td>Did you feel able to ask staff questions?</td>
<td>8-15 children</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>62</td>
<td>Did the hospital staff answer your questions?</td>
<td>8-15 children</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>63</td>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 children</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>66</td>
<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 children</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>69</td>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8-15 children</td>
<td>9.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>70</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15 children</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>72</td>
<td>When you left hospital, did you know what was going to happen next with your care?</td>
<td>8-15 children</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-15 children = asked of children aged from eight to 15 years of age
12-15 children = asked of children aged from 12 to 15 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served.

However, it worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The trust had worked closely with stakeholders, such as the clinical commissioning group and external agencies including Health Education, England, to develop the operating policy for children’s and young people’s services at the Pilgrim hospital, based on the needs of the local population. It was recognised that whilst centralisation of children’s and young people’s services on the Lincoln County hospital site was more economical and more easily sustainable, it would reduce the accessibility of the service for vulnerable groups. The trust provided evidence of regular meetings with stakeholders and their involvement in development of the ‘two sites one model,’ plans for children’s services in Lincolnshire.

The current operating model had been agreed with stakeholders and they were involved in the children’s and young people’s steering group. Managers and staff were constantly reviewing the operating policy and making adjustments based on local need. However, some of the decision made in real time were based on responding to a specific patient group’s needs and were not always previously agreed by the trust.
Managers told us they had attended the local Health Overview and Scrutiny Committee and Healthy Conversations Lincs, to discuss children’s and young people’s services at the Pilgrim hospital.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Ward 4A had mostly single room accommodation with only two four bedded bays. Due to a reduction in agreed capacity, there was flexibility in the use of the accommodation and staff showed a good understanding of the requirements for single sex accommodation and were able to accommodate the mix of age ranges of children attending the unit, to give privacy when required.

Facilities and premises were not always appropriate for the services being delivered. Some of the premises were designed for the delivery of children’s and young people’s services; others had been adapted and this had been done in a way that supported the service well; however, other areas did not fully meet the needs of the service and staff had not been supported by the provider to adapt the areas for the service.

There were no facilities within the children’s outpatient department for children with additional needs who might be distressed by a noisy environment. Outpatient staff said they had submitted a fully referenced paper, making the case for this type of room in 2015 and had raised the issue on a number of occasions since, but had received no response to their requests. There were no changing room facilities for older children with mobility issues. Staff told us plans were being considered for the development of a changing rooms facility in line with national guidance. However, there was a large waiting area for younger children that was well equipped with toys and a separate waiting room for older children and teenagers.

The environment in the adult outpatient departments where children were frequently seen, such as the fracture clinic, was not suitable for the needs of children. There were no separate waiting areas for children and children waited alongside adults. No toys were available and there were no displays to create a child friendly environment.

The X ray department had a small separate waiting area for young children, however, we were told most children over five years waited in the main area alongside adults. The MRI and CT scanning areas had a quiet area that could be used for children if there was a wait, however, most children were brought straight from the ward to the scanning rooms.

Ward 4A was well equipped for the needs of the service and had accommodation suitable for parents to stay with their children. The environment on ward 4A and the neonatal unit was suitable for the current agreed bed capacity. The main nursery on the neonatal unit was not spacious but was adequate for the number of babies cared for. The unit had a single room that could be used for isolation of a baby with an infection. There was a treatment and stabilisation room on ward 4A for the initial treatment and assessment of seriously ill children, that was well equipped for the purpose.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities (AMSAT). Staff had access to advice from the children’s and adolescent mental health team 24 hours a day seven days a week for advice. However, we were told they did not accept referrals until the child or young person was medically fit.

The service had systems to care for children and young people in need of additional support, specialist intervention. However, planning for transition to adult services was not fully established and only young people with diabetes had access to formal transition clinics. Transition clinics were held jointly with adult services for young people with diabetes. However, these transition clinics were not held regularly, due to difficulties in scheduling appointments with medical staff from adults and paediatrics. There were no transition clinics at the Pilgrim hospital for children with other long term conditions. There were no transition plans recorded for individual children. All actions were documented in the medical and nursing records and standard care plan.

Children and young people with on-going nursing needs had an allocated community children’s nurse to coordinate their care and a responsible consultant for their medical care.
Managers monitored and took action to minimise missed appointments. Staff recorded in notes when patients did not attend an outpatient appointment and a second appointment was sent. If the appointment was missed for a second time the consultant was informed and staff contacted the health visitors or school nurses to discuss the situation. They told us they would contact social services and make a safeguarding referral.

Managers did not ensure that children, young people and families who did not attend appointments were contacted. Staff said they did not have the facility within the outpatient department to initiate a text reminder system although they thought the central booking system did this routinely. They did not contact families themselves to explore reasons for non-attendance.

The service relieved pressure on other departments when they could treat children and young people in a day. The paediatric assessment facility enabled children attending the emergency department to be transferred and treated, relieving pressure on the emergency department. Staff from ward 4A provided assistance to the emergency department in relation to the treatment of a sick child when they were contacted.

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for each of the 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 number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>5</td>
<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>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>25</td>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>26</td>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>28</td>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>55</td>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 children</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>8</td>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>24</td>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>37</td>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>38</td>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>40</td>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Age</td>
<td>Rating</td>
<td>Comparison</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15</td>
<td>7.5</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Did you like the hospital food?</td>
<td>8-15</td>
<td>7.5</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15</td>
<td>7.4</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15</td>
<td>8.6</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Did the hospital give you a choice of admission dates?</td>
<td>0-7</td>
<td>4.0</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7</td>
<td>9.2</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
</tbody>
</table>

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12-15 children = asked of children aged from 12 to 15 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

### Meeting people’s individual needs

The service was inclusive but did not always take account of children, young people and their family’s individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.

However, they coordinated care with other services and providers.

Staff did not always make sure children and young people living with mental health problems, learning disabilities and long term conditions received the necessary care to meet all their needs. (AMSAT) Staff had received some training in the care of children and young people with mental health needs. They sought advice from the specialist teams and provided one to one support when necessary.

However, staff were not aware of any alerts on patient records or on the patient administration system to make them aware of patients with a learning disability for example, who may need adjustments to be made to cater for their additional needs.

During the inspection a child with additional needs was admitted for day case surgery. Their records showed that their long term condition had been identified at pre-operative assessment, but it was not flagged. It was also documented by the anaesthetist when the child was assessed following admission. However, no adjustments were made to reduce the waiting time for the child, or to place them first on the list. They were admitted at 11.30am and were expecting to go to theatre at approximately 2pm; however, did not go to theatre until 4pm. During the extended wait the child became distressed and anxious. Nursing staff liaised closely with the family and they enabled them to leave the ward for a short period to ease the child’s distress. However, the surgeon told a nurse that they had listed the surgery in age order, as the child had not shown signs of agitation or distress at their outpatient visit. This did not demonstrate an understanding of the needs of children and young people with additional needs.

The X ray department had distraction boxes with a range of toys and aids to distract children and reduce their anxiety. They told us they provided orientation visits for patients with additional needs if their carer made contact. However, they said that when referrals were made, they didn’t have the information about the patient’s needs to enable them to offer this proactively.
Wards were designed to meet the needs of children, young people and their families. Ward 4A had facilities to meet the needs of children, young people and their families. There was room by the child’s bed and in the side rooms for parents to stay with their child and beds were provided. There was a large playroom for younger children and day attenders. There was also a small room for older children and young people equipped with a television, computer games and CDs suitable for older children. There were facilities for parents on both ward 4A and the neonatal unit where parents could stay overnight close to their baby or child if they did not want to remain at the bedside. These had en-suite facilities and there was a separate kitchen when parents could make hot drinks and a supply of basic food stuffs such as milk, cereals and bread.

The children's outpatient department had consulting rooms that were large enough to accommodate children and young people with mobility issues. There were toys and distraction items in the consulting rooms.

Staff used transition plans to support young people moving on to adult services. We did not see evidence of formal transition plans in place, however, when young people attended transition clinics a record of their visit was documented along with any agreed actions.

Staff did not always support children and young people living with complex health care needs by using ‘This is me’ documents and passports. Children and young people’s individual needs were assessed on admission and in pre-operative assessment clinics, and staff used “This is me” documents when children and young people brought them in. However, we did not see the use of the documents initiated for one child admitted for surgery. Staff had access to learning disabilities nurses employed by the neighbouring mental health trust for support and advice when required. A risk assessment, screening tool and referral pathway were in place, the ward had a resource folder and there was local level training. Patients with very complex needs were often already known to the specialist nurses and they sometimes accompanied them without the need for contact from staff.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. The children’s outpatient department used symbols on the doors to rooms to improve accessibility for people with difficulties with the written word. Staff on ward 4A had a variety of pain assessment scales to ensure they could be used for children with a range of needs. They had access to picture communication aids for use with children and young people with difficulties in understanding and using verbal communication.

The service did not have information leaflets readily available in languages spoken by the children, young people, their families and local community. The service had a wide range of national and local information leaflets available on a range of subjects. However, we only saw these in English. Locally published information leaflets stated (in English) on the back that they could be obtained in another language, large print, audio or braille from the patient information team. There were information booklets for children of different ages about specific imaging such as MRI scans. This included picture booklets that could be used with children with no reading skills.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. The service had access to a telephone interpreting service. Staff told us they used this when patients were admitted and for updating patient of the care of their child and to enable them to ask questions. They said they were able to obtain face to face interpreters for specific situations such as discharge planning, however, it was not always possible to obtain an interpreter and it was dependent on the specific language required. The trust told us reported than in 2018/2019 they 98% of requests for telephone or face to face interpreters were fulfilled.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. Parents and children told us they had a good range of choices that met their individual needs.

**Access and flow**

**Arrangements to transfer and discharge children and young people were not always in**
line with the operational policy of the unit. Information about waiting times from referral to treatment for planned surgery were not available.

However, children and young people could access the service when they needed it and received the right care promptly.

Neonatal Critical Care Bed Occupancy

From February 2018 to May 2018, the trust had a neonatal critical care bed occupancy rate of 0%. However, from June 2018 to January 2019, the trust’s neonatal bed occupancy was 100% in every month. This was higher than the England average. However, bed occupancy should be interpreted with care due to the fact that there are only two neonatal critical care beds available in the trust.

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Managers and staff worked to make sure children and young people did not stay longer than they needed to. However, due to difficulties with transfer, patients requiring transfer to other hospitals were sometimes delayed.

Patients were admitted to the paediatric assessment unit on ward 4A, from the emergency department, via their GP, the community care nurses, or midwives. The operational policy stated patient would stay for a maximum of 12 hours, and if they were likely to require a longer hospital stay, they would be transferred to Lincoln County hospital or a tertiary hospital. Staff reviewed patients at eight and ten hours to identify whether they required transfer or whether they would be able to be discharged within the 12 hour maximum. However, capacity issues at the surrounding hospitals sometimes meant it was not possible to find an alternative hospital bed and patients therefore stayed for a longer period until a bed was available or they were ready for discharge. A snapshot of length of stay in the unit for the week of 11 February 2019 to 17 February 2019 provided by the trust showed that the average length of stay was above 12 hours on three of the seven days and the maximum length of stay rose to 53 hours on one day. Average length of stay in the three months from January 2019 to March 2019 ranged from 11.9 hours to 15.7 hours. Data provided by the trust showed that in the two month period from 28 March 2019 to 29 May 2019, 33 patients were reported as exceeding the 12 hour maximum stay. The information provided did not identify the reason for the patient not being transferred in some cases, or the actual length of stay.

Managers did not fully monitor waiting times and make sure children, young people and families could access services when needed and received treatment within agreed timeframes and national targets. Following our last inspection in March 2018, we told the trust they must ensure there was ongoing clinical risk assessment undertaken to ensure that children waiting surgery were clinically triaged and prioritised. At this inspection we did not find the trust had made
significant progress in this area. A paediatric surgical group had been established and met monthly. The senior management team said a task and finish group were looking at waiting times and from the week of the inspection, they would be able to obtain the information required to monitor waiting times from the patient tracking list database. This would allow them to move forward to monitor, triage and prioritise children and young people waiting for surgery.

Managers monitored waiting times and made sure children, young people and families could access emergency services when needed and received treatment within agreed timeframes and national targets. The service monitored the time from arrival in the paediatric assessment unit to assessment by a paediatric doctor to ensure it remained within the four hour target. There was consultant involvement in medical handover three times a day and this ensured patients were reviewed by a consultant in a timely way.

Managers worked to keep the number of cancelled operations to a minimum. The trust did not separate cancelled operations of children and young people, from overall cancelled operations data for surgery. The trust had established ‘6,4,2’ meetings to maximise theatre efficiency and reduce cancellations. Six weeks prior to an operating list, patients on the operating list were reviewed, again at four weeks and in more detail at two weeks. This helped to ensure any potential issues were identified and dealt with prior to the date of admission.

When children and young people had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff told us they tried not to cancel children and young people and when this was unavoidable, they re-arranged the surgery as soon as possible. However, they did not have specific data for children’s and young people’s services.

Staff did not move children and young people between wards at night unless there was an urgent clinical need.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning started prior to admission for children admitted for day surgery and discharge arrangements were clear. If there were any doubt about the ability to discharge a patient on the day of surgery, they were not offered surgery at the Pilgrim hospital, in line with their operating policy.

The operational policy for the paediatric assessment unit was to stabilise patients, and if they required a hospital stay of more than 12 hours, they were to be transferred to an inpatient bed at another hospital. Staff therefore monitored patients’ progress and started planning discharge from admission. Arrangements were made to transfer those not able to be discharged.

There was a medical handover three times daily, when patients were reviewed and discharge plans were discussed.

Planning for discharge started early on the neonatal unit as parents were supported to gain any additional skills they needed to care for their baby at home.

Staff planned children and young peoples’ discharge carefully, particularly for those with complex mental health and social care needs (AMSAT). Staff had multi-disciplinary discharge meetings for children and young people with complex health or social care needs. We observed parents being taught the skills they would require following discharge to support their child at home. We also observed parents were taught paediatric basic life support to enable them to respond in an emergency situation.

Managers monitored the number of delayed discharges. Staff completed an exception report form, when children and young people stayed on the paediatric assessment unit for longer than 12 hours.

Staff supported children, young people and their families when they were referred or transferred between services. Staff provided support to parents when babies, children or young people required transfer to a tertiary centre. They provided practical information and advice and emotional support. The neonatal unit provided journey boxes for babies and families who had to be
transferred to a tertiary centre that included all that they might need initially and a sum of money to help with transport costs for the parents.

Managers monitored patient transfers and followed national standards. The service had a transfer policy and managers monitored transfers and reported them to the children’s and young people’s steering group.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Children, young people and families knew how to complain or raise concerns. Parents we spoke with, said they would raise any concerns with the ward sister and most parents were aware of the patient advice and liaison service (PALS).

The service clearly displayed information about how to raise a concern in patient areas. Information leaflets were readily available in the information leaflets racks in all clinical areas and departments. These provided information about PALS and the complaints department. They also provided details of the parliamentary and health service ombudsman, Healthwatch Lincolnshire and an independent advocacy service.

Staff understood the policy on complaints and knew how to handle them. Staff were aware of the complaints policy and told us if patients raised concerns with them they would listen and try and rectify the issue immediately if they could and advise them of the complaints process and the role of PALS. They also said they would report any complaints to the ward sister who would carry out an investigation.

Managers investigated complaints and identified themes. Staff on ward 4A said the main reason for complaints were related to the need to transfer patients to other hospitals out of the locality. They reviewed complaints regularly with their matron.

**Pilgrim Hospital**

From March 2018 to February 2019, Pilgrim Hospital received 13 complaints in relation to services for children and young people. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>5</td>
<td>38.5%</td>
</tr>
<tr>
<td>Values and Behaviour</td>
<td>2</td>
<td>15.4%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td>No Consent</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td>Trust admin/policies/procedures including patient record management</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>13</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.
Managers shared feedback from complaints with staff and learning was used to improve the
service. Staff told us their ward sister shared feedback from complaints at staff meetings and they
discussed ways of preventing a similar complaint in the future.

**Number of compliments made to the trust**

**Pilgrim Hospital**

From March 2018 to February 2019, there were 302 compliments about services for children and
young people at Pilgrim Hospital. A breakdown of compliments by department is below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>March 2018 to February 2019</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neo Natal Unit</td>
<td>300</td>
<td>99.3%</td>
</tr>
<tr>
<td>Children's Ward</td>
<td>2</td>
<td>0.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>302</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Is the service well-led?**

**Leadership**

**Previous leaders had not always managed, or had lacked capacity or resources to manage, the priorities for improvement of the service.**

**However, the newly appointed leaders had the integrity, skills and abilities to run the service. They understood issues the service faced. They were visible and approachable in the service for patients and staff.**

A lack of stable on-going leadership capacity since the last inspection, had limited the progress made against the priorities for improvement for children’s and young people’s services. Children’s and young people’s services were managed within the division of family health. The trust had introduced a new model for the management of children's and young people’s services across the two hospital sites (‘two sites, one model) and the senior management team came into post on 1st April 2019. The team told us they were in the process of establishing roles of responsibilities and recruiting staff to the roles supporting the senior team. For example, a matron was in post for neonates; there was an interim matron in post for paediatrics and a permanent appointment had been made to the matron post. However, it was recognised a lead nurse for children’s and young people’s services was required and the senior management team told us it had not been possible to recruit into the role at the time of the inspection. They were in the process of identifying clinical leads for governance and audit for paediatrics and these were not currently established.

Key concerns identified in our last inspection in March 2018, had not been fully addressed and progress had been slow under the previous management structure. However, the newly appointed senior management team had a good understanding of the challenges and had started to put systems and processes in place to address the issues. They were moving forward with the children’s surgery group and establishing a governance structure.

Job plans for consultants had not been reviewed since 2017, although we were told a group job plan was being developed and individual job plans were to be reviewed. During this process, leads for clinical audit would be identified and attendance at 70% of clinical governance meetings would be mandatory.

There was a lack of adherence to the operating policy for children’s and young people’s services at the Pilgrim hospital and clinicians responsible for decision making about transfer of patients had
not been fully engaged in decisions about the operating policy. The trust had worked with external stakeholders to develop the operating policy for the service. However, in practice, adherence to the operating policy was not always possible and, in the view of some clinicians, it was flawed. The trust had commissioned a private provider of patient transport services to provide rapid transfer of children and young people, who did not require an intensive care facility, to Lincoln County hospital or another of the surrounding acute trusts. However, the service was unable to transfer certain categories of patient safely and appropriately qualified staff at the Pilgrim hospital were not available to accompany and treat the patient en-route. As a result, high dependency patients were not transferred to other acute services and patients who were less unwell were transferred. Clinicians had also made the decision not to transfer some other categories of patient, as they felt better outcomes could be achieved for the patients if they remained at the Pilgrim hospital. During the inspection a member of staff told us inpatients had been transferred from the children’s wards at Lincoln County hospital to the Pilgrim hospital, when there was pressure on availability of inpatient beds at Lincoln. This was not in line with the operating policy for ward 4A. Data provided by the trust indicated this had happened on five occasions during 2018/2019.

A steering group for children’s and young people’s service, reviewed data and information provided about the operation of the service against the agreed policy and were considering a change to the agreed length of stay and categories of patients cared for, following consultation and agreement by the trust board. Significant challenges in sustaining medical staffing levels remained a key issue for the service and a significant turnover of staff, reduced stability and increased the fragility of the service. However, reports to the trust board in March and April 2019 on the service, stated that the service, although fragile, was stable, and recommended a reduction in reporting frequency to quarterly. A detailed report in March 2019 identified the concerns of the consultants in relation to medical staffing and identified the length of stay sometimes exceeded 12 hours. A snapshot of length of stay in the unit for the week of 11 February 2019 to 17 February 2019 showed that the average length of stay was above 12 hours on three of the seven days and the maximum length of stay rose to 53 hours on one day. The report gave information on transfers and stated that some patients with high dependency needs stayed on the unit for stabilisation; it did not identify the restrictions of the private ambulance contract. We were therefore not assured that the board were fully appraised of the ongoing challenges to the operating model and staffing of the service.

The matrons and divisional leadership team had responsibilities for children’s and young people’s services across both hospital sites and were based at Lincoln County hospital. The matrons told us they visited the service at the Pilgrim hospital at least once or twice a week and were available by telephone at other times. If there was an issue at the Pilgrim hospital when they were at Lincoln, they would attend if necessary. The senior management team said they visited the Pilgrim on days when the matron was not on site, to maximise the leadership presence on site. However, this was not borne out in the week of the inspection.

Staff told us the matrons provided a good level of support and leadership. They were able to speak openly with matrons about issues and they said communication and joint working between staff at Lincoln and Boston had improved over the last year. Staff praised the ward sisters on the children’s ward and the neonatal unit for their leadership, the support they provided and for their knowledge and expertise. They told us they were fair and treated everyone equally and respectfully. A matron and a ward sister we spoke with, had a good understanding of the issues and the performance of their areas in relation to quality and workforce and had plans for improvement. They were positive and committed to the service.

Vision and strategy

The service had a vision for what it wanted to achieve and was developing a strategy to turn it into action, with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
The trust had identified their vision for the trust: to provide excellence in rural healthcare. Staff were aware of the trust values which were as follows:

- Patient Centred
- Safety
- Compassion
- Respect
- Excellence

They had a strategy 2019 to 2024 which set out the priorities for the trust and objectives for delivery. It committed the trust to a system wide approach to improving health and social care across Lincolnshire in partnership with other stakeholders. The strategy committed to providing a paediatric consolidated inpatient (emergency and elective) service for Lincolnshire at Lincoln County hospital and a paediatric assessment unit at Pilgrim hospital, with consultant led neonatal services at both sites.

The trust had collaborated with stakeholders in Lincolnshire to develop plans for the provision of children’s and young people’s services across the county and were partners in the strategic transformation partnership. There was a children’s and young people’s transformation board which reported to the overall strategic transformation partnership (STP) board. This oversaw the development of children’s and young people’s services in conjunction with external stakeholders.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The focus for all staff was on providing high quality clinical care for children and young people and a positive experience. Staff spoke of some of the challenges for children’s and young people’s services at the Pilgrim hospital, but a dedication to provide the best service possible for patients, came through in all our discussions with staff. One member of staff said, “Regardless of the issues, everyone wants to do their best for the children.”

Local leaders promoted a positive culture that supported and valued staff, although some staff said they felt ‘like the poor relations’ and felt as though the service was often overlooked, as Lincoln County hospital was the bigger site. However, staff also told us that the new leadership model felt, “more positive,” and staff were happy to integrate as part of the overarching team.

There was a no-blame approach used with respect to complaints, incidents, and errors. Staff were confident in raising concerns and felt they would be acted upon. Staff were aware of the role of the Freedom to Speak up Guardian.

**Governance**

Leaders did not operate fully effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities but did not always have regular opportunities to meet, discuss and learn from the performance of the service.

Clinical governance processes were not fully established and effective; there was a wide variability in staff knowledge about clinical governance meetings and involvement in them. Information was not always cascaded from board to ward in a systematic way. The senior management team explained that the governance framework and meeting structure had been reviewed as part of the new ‘two sites one model’ approach and some parts were more established than others. They told
us the terms of reference for each group were being reviewed, to ensure consistency and to ensure the key components of governance were included as standing agenda items.

There were separate clinical governance meetings for paediatrics and for neonates and both met monthly. We were told the neonatal governance meetings were better established and there was good attendance from consultants, senior nurses and managers, although junior doctor attendance was variable. Consultants we spoke with, were aware of the meetings and they found them useful.

However, paediatric meetings were less well established and some consultants were not aware they were occurring. There was one meeting for both sites and more recently, the meetings had been held at Lincoln County hospital, with video conferencing facilities for Pilgrim hospital. There had been significant issues with the video conferencing system, which was about to be replaced and this may have been a factor in engagement of staff in the meetings. Senior staff told us the meetings needed to be re-established and the content of the agenda needed to be agreed.

The trust did not provide minutes of the paediatric governance meetings. Minutes of the neonatal governance meetings provided by the trust showed a structured approach with patient safety, patient experience, clinical effectiveness and the risk register as standing agenda items. However, within these sections there was variable review of issues. They did not show evidence of a regular review of incidents (except for some individual incidents on one occasion) and/or review of the timeliness of investigation of incidents, development and review of an annual clinical audit plan, or review of and compliance with new NICE guidance.

The specialty clinical governance groups reported to the divisional clinical cabinet and then to the quality and safety oversight committee.

Although there was an identified clinical audit lead for neonates, there was no clinical audit lead for paediatrics. The trust provided a copy of the planned audits for 2019 to 2020, but there were only six audits planned for children and young people’s services across the trust. Minutes of the children’s and young people’s surgery committee demonstrated surgical audits were being considered and a small number were planned for the coming year.

There were no arrangements in place for paediatric morbidity and mortality meetings. The need to establish paediatric morbidity and mortality meetings was a requirement following our last inspection in March 2018.

There was a quality and safety improvement plan for children’s and young people’s services. This identified the main priorities for the development of children’s services over a 12 month period. However, we found some of the milestones had not been met. For example, actions such as the development of a robust audit plan to ensure evidence-based care is applied to Children and Young People and suitable, was due to be complete in February 2019. Suitable provision of activities for children and young people within the environments they are cared for, was to be completed in the same timeframe. Risk registers reflect where national standards/guidance are currently not met with clear plans for mitigation / managing the risk was not complete.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. Staff did not always contribute to decision-making to help avoid financial pressures compromising the quality of care. They had plans to cope with unexpected events.

The service maintained a divisional risk register, which identified the clinical business unit to which each risk applied (children’s and young person’s) and which defined the severity and priority of risks with the potential to cause harm to patients or staff. Planned actions to reduce each of the
risks were listed, along with the lead person responsible for the action. However, the description of the risk was lengthy and frequently unclear and there was some duplication. For example, risks associated with insufficient medical staff were contributory factors under several risk descriptions and different planned actions were listed. Another description of risk stated the risk was caused by issues with the design or application of patient care policies, guidelines and pathways. One of the weaknesses or gaps in the controls was stated to be that children requiring a higher level of care, had to be transferred with an escort provided by nursing and medical staff from the ward, which depleted staffing and staff did not use transfer skills regularly enough to maintain their competency. The planned action associated with this was that any uplift in nursing establishments needed to take potential transfers into account. There was no indication of a clear plan to obtain the medical and nursing staff required for this role, or how their skills would be developed and maintained, or an alternative plan for transferring the patients. The risk register did not clearly identify the risks associated with the inability of the private ambulance service to transfer children with high dependency needs, or the risks of not transferring children with newly diagnosed diabetes and diabetic ketoacidosis. We were told a risk assessment in relation to keeping children for over 12 hours had been completed; however, when we requested a copy of the risk assessment, we were provided with a list of all the reported incidents in a two month period. We therefore concluded a risk assessment was not available. There was no record of the risks associated with the lack of capacity to carry out audits of compliance with NICE and other national guidance for example. A risk we identified during the inspection, in relation to access to the children’s ward through the porters lift, was not included on the risk register and a risk assessment had not been completed.

Divisional performance reports were produced, monitoring operational performance, finance, quality and workforce indicators. The purpose was to provide an insight into how the individual directorates contributed to the overall trust performance. Issues arising from the performance meetings were escalated to the relevant Board committee and to the Trust Management Group where appropriate.

The senior management team said they currently didn’t have a ward performance dashboard to monitor quality performance indicators for the children’s ward and the neonatal unit and this was an area for development. However, they sent us copies of a ward health check that was used to monitor safety and quality issues, patient experience and workforce indicators across the trust. This included ward 4A and the neonatal unit. This gave a red, amber or green rating to the indicators to show at a glance how the ward was doing in relation to each indicator. We did not see discussion of this at the neonatal governance meetings.

The trust had developed and introduced a ward accreditation programme to set goals in relation to quality and safety indicators and monitor progress and performance. This had been implemented on the adult wards and we were told a plan was in place to introduce this to children’s and young people’s services. The paediatric matron said they monitored data on a monthly basis on performance indicators such as hand hygiene compliance, pressure ulcers, sepsis, staff appraisals, and mandatory training. They collated information which fed into a governance report which was reported to the divisional governance meetings. They told us the governance committee was starting to challenge and monitor the information. However, we did not see evidence of this in the neonatal governance meeting minutes and the trust did not provide minutes of paediatric governance meetings.

At our last inspection in March 2018, we asked the trust to ensure there were defined governance structures in place to assure the board of the quality and delivery of surgical care to children. In addition, we asked the trust to ensure there was multi-disciplinary children’s surgery committee which report to the board. A multi-disciplinary children’s surgery committee was in place and it met monthly. It reported to the children’s and young people’s transformation board, which reported to the quality governance committee. This was a board sub-committee. Progress on the paediatric assessment unit was reported regularly to the trust board. However, we did not see any mention of children’s surgery within reports to the trust board.
The trust had a major incident plan. Staff could access the plan on the trust intranet. Managers told us there had not been any recent training or practice events to ensure staff were aware of their responsibilities. The trust had a business continuity plan which provided guidance on maintaining services and dealing with business interruptions, which might disable services or require special arrangements to be put in place to allow them to continue.

Information management

The service collected reliable data and analysed it. Staff could mostly find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not fully integrated although were secure.

The service had a range of information available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance, and finances. Each of the indicators was given an equal rating. The trust produced a monthly divisional performance report which listed performance against performance indicators monthly. The divisional performance report was reviewed at divisional meetings attended by the divisional leadership team. Leaders within the service had a good knowledge of performance and where further improvements were needed. Information was used to measure improvement.

However, the paediatric surgery group had not had access to patient tracking list data to enable them to monitor and risk assess waiting times of children and young people. The senior management team told us work had been done to rectify this and the data would be available from the week of the inspection.

Ward sisters had access to data and information to help them monitor their performance and identify where improvements were needed. The electronic white board on ward 4A allowed staff to gain a snapshot of the ward, and key patient parameters such as PEWs and length of stay, whilst maintaining confidentiality.

Managers were aware of some issues with the quality of their data and were working to address these. Electronic systems were not fully integrated and there a number of different systems were in use. Systems did not always work together which prevented the cross referencing of data automatically. There were processes in place to ensure the trust remained sighted on such issues.

Engagement

Leaders and staff actively and openly engaged with patients, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However, staff did not always feel engaged in decision making about the service.

Management and clinicians did not always work cohesively together. We identified concerns with communication processes within the service, leading to a feeling from some staff that senior managers were not engaging with them, and from managers that some staff were not fully engaged. Some staff felt the trust management team made decisions without their involvement. This was an issue for some medical staff and also nursing staff. Some consultants felt they weren’t included in the decisions about the change to a 12 hour paediatric assessment unit and more recently to move some inpatients to the ward from other hospitals. Although the decisions were communicated to them, they did not feel they had an influence on the decisions. A nurse we spoke with said decisions were perceived to have been made behind closed doors and they said staff were informed of decisions to change the status of a part of the service, after a press leak. On the other hand there was a view that some staff were unwilling to engage with some management and governance processes.

The service engaged with local people as part of the paediatric services review at Pilgrim Hospital. (Source: Main PIR Engagement tab).
The trust provided us with information about their engagement with local community organisations. In all, they had contacted over 40 groups and attended 24 group meetings. This included children’s centres, church groups, toddler groups, a group for Polish migrants and an international children’s group. At these groups they encouraged people to give their opinions about paediatric services in the county. The trust also held engagement events five of which were held at Pilgrim hospital.

A regular paediatrics newsletter was produced for trust staff, members, stakeholders and others who had registered an interest (affected families). It provided regular updates on the interim service model and an opportunity to feed back.

The service had obtained ongoing feedback from families, when patients required transfer to other hospitals. However, senior managers recognised engagement with patients and the public could be better developed and be more proactive. They did not have forums for children and young people to provide their views on an ongoing basis, although staff in theatres told us they sought the views of some patients on the children’s ward, about planned changes to the environment for children and young people in the theatre recovery area and were looking at involving local schools in developing displays for the walls.

We observed posters in the ward areas highlighting ways parents and children could feedback about their experience and that their experience mattered. Feedback forms were given to parents on the neonatal unit prior to their baby’s discharge. Staff told us of changes they had made to ensure mothers did not miss their meals on the maternity ward when they were inpatients as a result of feedback they obtained.

The trust engaged with the Boston disability group which had patients with a range of physical disabilities including sensory issues and told us they had made local changes in the environment to aid access for patients in their own wheelchairs.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services, although progress to improve services was slow. They did not always have a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Action was not always taken when improvements were needed, or progress towards improvement was slow. The trust had appointed a project lead for the improvement programme, but they were no longer in post. A group of professionals from other organisations were delivering against identified priorities, mainly in relation to children admitted to the emergency department. However, this team were time limited.

At the last inspection in March 2018, we identified areas where improvement was needed. The current senior management team were appointed to their posts in April 2019; they had a grasp of the issues and started to put mechanisms in place to address the issues. However, we found significant progress in addressing issues in the interval since the last inspection had not always been made.

We found some improvements had occurred in the timely investigation of incidents and learning from incidents had improved, although the system for learning from incidents was not robust, due to a lack of established governance processes. There was a lack of progress in the following areas:

- There was no robust clinical audit plan to ensure evidence based practice was delivered
- Ensuring the delivery of care and treatment in line with evidence based practice. Although results from national audits showed elements of good practice, some clinical guidelines and policies were past the date when their review was due, increasing the risk that guidance was not based on the latest evidence.
• There were defined governance structures in place, however, terms of reference and standing agenda items were not finalised.

• Assurance that ongoing clinical risk assessment was undertaken to ensure that children waiting surgery were clinically triaged and prioritised was not possible, as the systems for obtaining the data required were only just being put into place.

• A formalised mechanism for instigating paediatric morbidity and mortality reviews across children’s services was not in place.

At our previous inspection in March 2018, we told they trust they must ensure there was a formalised mechanism for instigating paediatric morbidity and mortality reviews across children’s services. Morbidity and mortality reviews were held for babies in maternity and the neonatal unit. Minutes of the meetings showed there was a discussion of individual cases and any learning identified. However, there were no arrangements in place for morbidity and mortality reviews in paediatrics. The senior management team told us a review was completed when children died, but more work needed to be done to develop a formalised approach to morbidity and mortality reviews for children.

A children’s and young people’s surgery committee had been established and there was an agreed programme of work for with identified leads. However, significant progress was only just starting to occur.

Better births Lincolnshire was a partnership of all local stakeholders including the NHS trusts, clinical commissioning groups and the county council, to develop and implement a maternity transformation programme. There was a neonatal workstream within the maternity transformation programme and the trust was undertaking an assessment against the agreed plans and standards.