

United Lincolnshire Hospitals NHS Trust

Quality Report

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

Ratings

Overall rating for this trust	Inadequate 
Are services at this trust safe?	Inadequate 
Are services at this trust effective?	Requires improvement 
Are services at this trust caring?	Good 
Are services at this trust responsive?	Requires improvement 
Are services at this trust well-led?	Inadequate 

Summary of findings

Letter from the Chief Inspector of Hospitals

The United Lincolnshire Hospitals NHS Trust has three main hospitals and provides a range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services to the 700,000 people of Lincolnshire. The trust employs 7,500 staff.

We inspected United Lincolnshire Hospitals NHS Trust between the 10-14, 18-19 and 26-27 October 2016. We also carried out unannounced inspections to Lincoln County Hospital and Pilgrim Hospital on 24, 25 and 27 October 2016. On 19 December we carried out an unannounced inspection to Pilgrim Hospitals ED and medical wards in response to some information of concern we had received.

We included the following locations as part of the inspection:

- Lincoln County Hospital
- Pilgrim Hospital
- Grantham Hospital

We did not inspect County Hospital Louth, John Coupland Hospital in Gainsborough, Skegness and District General Hospital or the Johnson Community Hospital in Spalding.

We rated United Lincolnshire Hospitals NHS Trust as Inadequate overall.

We rated Pilgrim Hospital as Inadequate, Lincoln County Hospital as Requires Improvement, and Grantham Hospital as Good.

Our key findings were as follows:

Safety

- There were not robust arrangements in place to respond to emergencies and major incidents. A major incident plan and action cards were available but were not in date nor were they easily accessible to staff. Equipment for use in a major incident had not been checked and some was not in working order. The trust rectified these concerns following the inspection.
- Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of harm because they did not receive the correct treatment in a timely manner and in line with national and local guidelines.
- The trust was not assured it was meeting the obligations of the Duty of Candour regulation.
- The trust was not assured it had adequate arrangements in place to meet its safeguarding responsibilities.
- We identified risks to patient safety. There were no clear arrangements for out of hours gastrointestinal bleed treatment at Pilgrim Hospital.
- We were not assured all incidents were reported; nor were we assured that they were investigated in a timely way.
- We received a mixed picture regarding staff receiving feedback from incidents. Some areas were able to tell us they received feedback and learning through email and staff meetings. In other areas, staff did not feel they received feedback.
- We were not assured actions identified from root cause analysis investigations were being implemented to improve the safety of care being provided.
- Medicines related incidents were the second highest number of incidents reported in the trust. Between July to September 2016, omitted medicines accounted for 36% of all incidents reported in the trust. Of these 84 omissions related to critical medicines where there was a significant risk of harm if these medicines were delayed or omitted. This corresponded with data collected during the inspection week.
- We found staff knew how to report incidents through the trusts electronic incident reporting system.
- The trust used a nationally recognised staffing tool for to determine nursing staffing levels alongside patient acuity and dependency. We were told this was also used in conjunction with professional judgement principles.
- The proportion of consultants reported to be working at the trust was about the same as the England average. The proportion of junior doctors (foundation years one and two) reported to be working at the trust was higher than the England average.

Summary of findings

Effectiveness

- Whilst Information about patient's care and treatment, and their outcomes, was routinely collected and monitored, outcomes for patients were sometimes below expectations when compared with similar services at a national level.
- There were no protocols in place for the management and manipulation of fractures or fractured neck of femur (a crack or break in the top of the thigh bone).
- The trust used a maternity dashboard but the data was not rated to enable themes and trends or benchmarking comparisons to be easily made.
- There was no policy for restraining patients. The trust did not consistently record the numbers of patients who had received rapid tranquilisation medication or recorded any episodes of restraint of patients.
- Procedures, policies and clinical guidelines were easily accessible through the trust's intranet. Generally we found policies and procedures and clinical guidelines were up to date and reflected national guidance.
- Care pathways; multidisciplinary plans of anticipated care and timeframes were in place for specific conditions or sets of symptoms.
- Both of the hospitals endoscopy departments were Joint Advisory Group (JAG) accredited.
- Mortality Review Assurance Group (MoRAG) meetings were held monthly across all medical specialties to discuss patient deaths.
- Between April 2015 and March 2016, 60% of babies were born normally, which was the same as the England average. In the same period trust wide, caesarean section figures were the same as the England average at 26%.
- The trust submitted data to the sentinel stroke national audit programme (SSNAP). Lincoln County Hospital achieved grade B SSNAP level and Pilgrim hospital was rated as level C.
- Between February 2015 and January 2016, medical patients at the trust had a lower than expected risk of readmission for non-elective and elective admissions.

Caring

- We observed isolated instances at Pilgrim Hospital where staff had not treated patients with dignity, respect and compassion.
- At times, staff focused on the task instead of the patients as individuals. Staff were providing one to one

support for some patients as they had been assessed as being at increased risk. However, when providing one to one support, staff did not always engage with patients meaningfully.

- However, in most of the areas we inspected staff responded compassionately when patients required help and supported patients emotionally.
- Generally staff interacted positively with patients and we observed that patients were treated with kindness, dignity, respect and compassion while they receive care and treatment. Feedback from patients was mostly positive about the care and treatment they had received.
- The trust had introduced a carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carers badge encouraged carer involvement, particularly for patients with additional support needs.
- The trust's Friends and Family Test performance was generally worse than the England Average between October 2015 and September 2016. In the latest period, September 2016, the trusts performance was worse than the England average (91% compared to an England average of 96%).
- In the Cancer Patient Experience Survey 2015 the trust was not in the top 20% of trusts for any of the 50 questions, was in the middle 60% for 40 questions and in the bottom 20% for 10 questions.

Responsive

- Patients had been unable to access services in a timely way for an initial assessment, diagnosis or treatment including when cancer was suspected. During 2016 the trust has failed to meet the majority of the national standards for the cancer referral to treatment targets.
- The trust had failed to meet the national standard for the referral to treatment time for incomplete pathways for the previous three consecutive months.
- There were significant delays in patients receiving their follow up outpatient appointment across several specialities with 3,772 appointments being overdue by more than six weeks.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England overall performance between October 2015 and October 2016.

Summary of findings

- The trust reported a high number of bed moves (40%) over 11 months, 595 of which occurred after 10pm within a six-month reporting period.
- Systems were not robust to identify vulnerable patient groups which included patients living with dementia and patients with learning disabilities.
- Although there had been improvements in the management of complaints within the trust since our last inspection, the response times were still not in line with the trust's policy.
- The trust's bed occupancy rate was similar to the England average for Quarters 1 to 3 2015/2016 and below the England average for Q4 2015/2016.
- Site management meetings took place three times each day in the hospitals. These meetings were used to identify the number of available beds, patients who needed admission, were awaiting discharge or were on outlying wards.
- The chaplain teams represented a range of faiths and provided support across all beliefs. Bereavement services were also provided within the chaplaincy service. The team provided a range of specific services including hospital funerals, weddings, birth and death sacraments, memorial services, worship and Holy Communion.
- There were weaknesses in the trust's governance framework to support the delivery of good quality care and the trust's vision and strategy.
- We were not assured the board were sufficiently sited on risk.
- The trust did not have systems in place to ensure the Fit and Proper Person regulation was met. We looked at the files of four directors and found the checks made were inconsistent so assurances that directors were fit and proper persons were not in place.
- The trust had failed to respond to the concerns we raised in the 2014 and 2015 CQC inspections in relation to the outpatient service at Lincoln County Hospital.
- The trust had a vision and a set of values and generally staff knew about these.
- In the past two years, the governance arrangements in the maternity service had been strengthened significantly.
- Generally staff knew who the executive team were and felt the Chief Executive was approachable.
- Each hospital had a patient forum which was led by a non-executive director. Patient representatives attended the forums. In addition to this the trust worked with the local Healthwatch to obtain patient feedback.

Well led

- We found low levels of staff satisfaction coupled with high levels of stress and work overload. Some staff told us they did not feel respected, valued or appreciated.
- There was a theme in the focus groups and during our contacts with staff which centred on staff telling us they perceived they didn't feel confident to raise concerns within their work environments. We met with some staff on a one to one basis and talked with other staff in focus groups. Some staff told us they perceived they were being bullied or intimidated.
- Whilst it was isolated to a small number of wards at Pilgrim Hospital, we were not assured that all staff understood the values because we saw care being delivered that was not respectful or compassionate.
- The Friends and Family test scores were lower on average when compared with other trusts. The trust was within the 10% of lowest performing trusts in terms of percentage of patients who would recommend the ward/clinic.
- The trust's sickness levels between April 2015 and February 2016 were higher than the England average.

We saw several areas of outstanding practice including:

Lincoln County Hospital

- The emergency department (ED) inputted hourly data into a specific risk tool which had been created, to give an internal escalation level within ED separate to the site operational escalation level. This tool gave an "at a glance" look at the number of patients in ED, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building and there were local actions for easing pressure.
- The ED had designed and were using a discharge tool 'TRACKS' (T-transport, R-relatives/ residential home, A-attire, C-cannula, K-keys, S-safe) to facilitate the safe discharge of older and/or vulnerable patients.
- The trust had introduced a carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carer's

Summary of findings

badge encouraged carer involvement, particularly for patients with additional needs. Being signed up to the carer's badge also gave carers free parking whilst they were in attendance at the hospital.

- Ashby Ward had just introduced visits from pets called a therapy (PAT) dog. PAT is a charity and volunteers from PAT, along with their own pets, visit care organisations to enable patients to interact with them.
- On the care of the elderly wards a red, amber, green system was used to identify patients who required more assistance than others. Red signified those patients who required the most help, whilst green identified those patients who required the least. This system was also applied to each patient's menu card to signify the amount of support a patient required with eating. Patients with a green sticker were given their meals first. Staff who took meals to patients with a red sticker then stayed to support the patient to eat their meal.
- Staff on Nocton Ward had introduced sibling activity bags for any siblings of the infants admitted on the ward. This demonstrated a positive approach to involving the whole of the family in the service experience.

Pilgrim Hospital

- The emergency department (ED) was trialling the introduction of a hot meal for those patients who were able to eat at lunchtime.
- The ED inputted hourly data into a specific risk tool, which had been created, to give an internal escalation level within ED separate to the site operational escalation level. This tool gave an 'at a glance' look at the number of patients in ED, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building and there were local actions for easing pressure.
- In response to an identified need for early patient rehabilitation, a physiotherapy assistant had been employed to work within the critical care unit. Under the direction of a chartered physiotherapist, the assistant carried out a program of exercises with individual patients to support the rehabilitation

process. This included a variety of exercises including the use of cycle peddles to aid the maintenance of muscle tone. Staff spoke positively about this service and of the benefits to patient recovery.

- Staff on the children's ward had learnt sign language to enhance their communication skills with children who had hearing difficulties.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Grantham Hospital

- The emergency department (ED) inputted hourly data into a specific risk tool. The tool gave an "at a glance" look at the number of patients in ED, time to triage and first assessment, number of patients in resuscitation room, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building and there were local actions for easing pressure.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

Lincoln County Hospital

- The trust must take action to ensure staff in the emergency department are appropriately trained and supported to provide the care and support needed by patients at risk of self-harm.
- The trust must take action to ensure all staff working in the emergency department receive appropriate supervision, appraisal and training to enable them to fulfil the requirements of their role.
- The trust must take action to ensure systems and processes are effective in identifying where safety is being compromised and in responding appropriately and without delay. Specifically, systems and processes to identify and respond to the assessment and treatment of sepsis in the emergency department.
- The trust must take action to ensure staff have the appropriate qualifications, competence, skills and experience, in addition to paediatric life support, to care for and treat children safely in the emergency department.

Summary of findings

- The trust must continue to ensure systems and processes are effective and that staff respond appropriately in recognising and treating patients in line with the trust's sepsis six care bundle.
- The trust must take action to ensure ligature risk assessments are undertaken and that ligature cutters are available in all required areas.
- The trust must take action to ensure staff in maternity are appropriately trained and supported to provide recovery care for patient's post operatively.
- The trust must take action to ensure all staff working in the termination of pregnancy service receive formal counselling training.
- The trust must take action to ensure that the handover process on Nettleham Ward does not compromise patients' privacy.
- The trust must take action to ensure that sensitive patient groups are not mixed within gynaecology and maternity outpatient areas.
- The trust must ensure the environment within Clinic 6 is reviewed and actions taken to prevent or control the potential risk to patients from infections. The trust must comply with the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance.
- The trust must ensure that the drinking water dispensers are cleaned and maintained in accordance with the manufacturer's instructions including completion of scheduled electrical safety testing, a water hygiene maintenance programme and cleaning schedule.
- The trust must ensure that equipment is appropriately maintained. It must ensure any checks carried out by staff are recorded and done with sufficient frequency and with sufficient knowledge to minimise the risk of potential harm to patients.
- The trust must ensure that patients who are referred to the trust have their referrals reviewed in a timely manner to assess the degree of urgency of the referral.
- The trust must ensure that the patients who require follow up appointments are placed on the waiting list.
- The trust must ensure that there are processes in place to ensure that patients whose condition deteriorates are escalated appropriately.
- The trust must take action to ensure safety systems, processes and standard operating procedures are in place to ensure there is an on-call gastrointestinal bleed rota to protect patients from preventable harm.
- The trust must ensure that all staff have an appraisal and are up to date with mandatory training, and ensure staff in the emergency department have received appropriate safeguarding training.
- The trust must ensure staff have the appropriate qualifications, competence, skills and experience, in addition to paediatric life support, to care for and treat children safely in the emergency department.
- The trust must ensure there is an adequate standard of cleaning in the emergency department.
- The trust must ensure staff comply with hand decontamination in the emergency department.
- The trust must ensure that patient records in the emergency department are complete; specifically that risk assessments, pain scores and peripheral cannula care are documented.
- The trust must ensure patient records are kept securely in the ambulatory emergency care unit (AEC).
- The trust must ensure governance and risk management arrangements are robust and are suitable to protect patients from harm.
- The trust must take action to ensure there is a robust process in place to report incidents appropriately and investigate incidents in a timely manner and staff receive feedback, lessons are learnt and shared learning occurs.
- The trust must take action to ensure safety systems, processes and standard operating procedures are in place to ensure there is an on-call gastrointestinal bleed rota to protect patients from preventable harm.
- The trust must take action to ensure systems and processes are effective staff respond appropriately in administering treatment in the recommended time frame in accordance to the sepsis six bundle of care.
- The trust must take action to ensure systems, processes are in place to reduce the significant number of omitted medication doses, and any omissions recorded in accordance with trust policy.
- The trust must take action to ensure ligature risk assessments are undertaken in all required areas.

Pilgrim Hospital

- The trust must ensure systems and processes are effective in identifying and treating those patients at risk of sepsis.

Summary of findings

- The trust must take action to ensure ligature cutters are accessible and available when needed to meet the needs of people using the service.
- The trust must take action to ensure there are sufficient numbers of suitably qualified competent, skilled and experienced staff to meet the identified needs of patients.
- The trust must take action to ensure the Care Quality Commission (CQC) is informed about any DoLS applications made in line with Regulation 18 of the Health and Social Care Act 2008 (Registrations) Regulations 2014.
- The trust must include evidence of outcomes and learning from complaints within communication with staff.
- The trust must take action to ensure that people are told when something goes wrong.
- The trust must take action to ensure that emergency equipment in the antenatal day unit is checked when the unit is in use.
- The trust must take actions to ensure that staff within gynaecology have greater involvement in the reporting and monitoring of incidents. This would include sharing learning from historical incidents.
- The trust must take action to ensure staff in maternity are appropriately trained and supported to provide recovery care for patients post operatively.
- The trust must take action to ensure that all staff receive basic life support and infection prevention and control training.
- The trust must take action to ensure all staff working in the termination of pregnancy service receive formal counselling training.
- The trust must take action to ensure that all paperwork is correctly completed to ensure Human Tissue Authority guidance is followed in the disposal of fetal remains.
- The trust must take action to ensure that when gynaecology patients are admitted the inpatient records are found as soon as possible. Where temporary patient notes are created, these must be combined with inpatient records as quickly as possible.
- The trust must take action to ensure that the area designated as the labour ward recovery area is ready for use with privacy maintained at all times.
- The trust must complete a ligature risk assessment of the children's ward where Child and Adolescent Mental Health Services (CAMHS) patients are admitted.
- The trust must ensure paediatric medical staffing is compliant with the Royal College of Paediatrics and Child Health (RCPCH) standards.
- The trust must ensure nurse staffing on the children's ward is in accordance with Royal College of Nursing (RCN) (2013) staffing guidance.
- The trust must ensure there is at least one nurse per shift in all children's clinical areas trained in either advanced paediatric life support (APLS) or European paediatric life support (EPLS) as identified in the RCN (2013) staffing guidance.
- The trust must ensure staff adhere to the trust's screening guidelines for screening for sepsis.
- The trust must ensure the management of health records enables the safe care and treatment of patients, compliance with information governance requirements and ensures patient confidentiality is maintained. This includes the availability, the condition and storage of medical records.
- The trust must ensure that equipment is appropriately maintained. Ensure any checks carried out by staff are recorded and done with sufficient frequency and with sufficient knowledge to minimise the risk of potential harm to patients.
- The trust must ensure that patients who are referred to the trust have their referrals reviewed in a timely manner to assess the degree of urgency of the referral.
- The trust must ensure that the patients who require follow up appointments do not suffer unnecessary delays and are placed on the waiting list.
- The trust must ensure patients have complete and recorded outcomes to ensure there are documented decisions and actions in relation to their treatment and care.

Grantham Hospital

- The trust must take action to ensure that the environment in the emergency department is fit for purpose.
- The trust must take action to ensure staff have the appropriate qualifications, competence, skills and experience, in addition to paediatric life support, to care for and treat children safely in the emergency department.

Summary of findings

- The trust must ensure there are sufficient numbers of medical and nursing staff working in the emergency department who have up to date and appropriate adult and children resuscitation qualifications.

Provider wide

- The trust must take action to ensure they are compliant with the Fit and Proper Person requirement.
- The trust must ensure they are compliant with the requirements of the Duty of Candour.

- The trust must ensure there is good governance within the organisation.

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to United Lincolnshire Hospitals NHS Trust

The United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest trusts in the country. Through three main hospitals and four sites, the trust provides a range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services to the 700,000 people of Lincolnshire. The trust employs 7,500 staff and has three main hospitals: Pilgrim Hospital in Boston (391 beds), Grantham and District Hospital (110 beds) and Lincoln County Hospital (602 beds). The trust also provides services at County Hospital Louth, John Coupland Hospital in Gainsborough, Skegness and District General Hospital and the Johnson Community Hospital in Spalding.

Lincolnshire is a largely rural area with only 27 miles of dual carriageway in the county. This makes travel times lengthy and road injuries/deaths are common. In Lincolnshire, traffic-related injuries/deaths are significantly worse than the average for these types of injuries in England.

The county's average of Black, Asian and minority ethnic residents is lower than the English average – with the largest ethnic group being Asian (1.2%). There are medium levels of deprivation, but these levels have increased since 2007. The county has an ageing population, with a higher than average number of older residents.

Our inspection team

Our inspection team was led by:

Chair: Judy Gillow,

Head of Hospital Inspections: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a consultant surgeon, a medical consultant, registered nurses, allied health professionals, midwives and junior doctors.

We were also supported by two experts by experience that had personal experience of using, or caring for someone who used the type of service we were inspecting.

How we carried out this inspection

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

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

Before our inspection, we reviewed a wide range of information about United Lincolnshire Hospitals NHS Trust and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, National Health Service Intelligence (NHSI), Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team. We also spoke with patients and members of the public as part of our inspection.

The announced inspection took place between the 10-14, 18-19 and 26-27 October 2016. We held focus groups with

Summary of findings

a range of staff throughout the trust, including, nurses, midwives, junior and middle grade doctors, consultants, administrative and clerical staff, physiotherapists, pharmacy staff and occupational therapists, porters and ancillary staff. We also spoke with staff individually.

We also carried out unannounced inspections to Lincoln County Hospital and Pilgrim Hospital on 24, 25 and 27 October 2016.

What people who use the trust's services say

The Friends and Family test scores were lower average when compared with other trusts. This test is based on a question asked of patients in all NHS trusts in England, "How likely are you to recommend this ward/clinic to friends and family if they needed similar care or treatment." In October 2016 the trust scored:

- Inpatient services 92% (NHS average (95%)
- Urgent and emergency services 81% (NHS average 87%)
- Outpatient services 93% (NHS average 93%)
- Maternity services for birth 100% (NHS average 96%) the response rate for this score was only 2.3%

The CQC Adult Inpatient Survey 2015 received responses from 607 patients. The survey asks questions under 11 areas. The trust was rated about the same as other trusts for all 11 areas, however, the questions relating to patients being **asked to give their views** about the quality of their care and being given enough **information** on their condition or treatment scored worse when compared with other trusts.

In the Cancer Patient Experience Survey 2015 the trust was not in the top 20% of trusts for any of the 50 questions, in the middle 60% for 40 questions and in the bottom 20% for 10 questions.

The trust performed worse than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to Cleanliness, Food, Privacy/dignity/wellbeing and Facilities. Performance had slightly improved in 2016 compared to 2015 for Cleanliness, Food and Facilities but had worsened for Privacy/dignity/wellbeing.

We received information from people through emails, our website and through phone calls prior to and during this inspection. Responses were mixed, some patients spoke very highly of the care they had received whilst others raised concerns. The information was used by the inspectors through the inspection process.

Facts and data about this trust

United Lincolnshire Hospitals NHS Trust has the following registered locations:

- Lincoln County Hospital
- Grantham & District Hospital
- Pilgrim Hospital, Boston
- County Hospital, Louth

The trust has a total of 1312 beds spread across various core services:

- 681 Medical beds
- 460 Surgical beds

- 87 Children's beds
- 55 Maternity beds
- 29 Critical Care beds

There are 686 beds (inpatient & day case) at Lincoln County Hospital and 461 at Pilgrim Hospital.

The trust's main CCG (Clinical Commissioning Group) is Lincolnshire East CCG. The trust primarily serves a population of over 720,000 people, situated in the county of Lincolnshire. It is one of the largest acute hospital trusts in England.

Summary of findings

As at June 2016, the trust employed 7478 staff and had an average vacancy rate of 13%. A breakdown by staff groups is below:

Staff Group

WTE (Staff in post)
Establishment

Medical Staff

792.69

928.11

Nursing and Midwifery Staff

1925.79

2208.09

Allied Health Professionals

350.67

394.26

Other Clinical Staff

1497.92

1379.52

Other Non-Clinical Staff

1874.22

2037.16

Any other staff

4.80

2.00

Total Staff

In the 2014/15 financial year the trust had an income of £433,250,000, and costs of £448,528,000, resulting in a deficit of -£15,278,000 for the year. The trust predicts that it will have a surplus/deficit of £65,800,000 in 2015/16.

In 2015/16 the trust had:

- 154,000 A&E attendances.
- 696,052 outpatient appointments

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated safe as inadequate because:</p> <ul style="list-style-type: none">• There were not robust arrangements in place to respond to emergencies and major incidents. A major incident plan and action cards were available but were not in date nor were they easily accessible to staff. Equipment for use in a major incident had not been checked and some was not in working order. The trust rectified these concerns following the inspection.• Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of harm because they did not receive the correct treatment in a timely manner and in line with national and local guidelines.• The trust was not assured it was meeting the obligations of the Duty of Candour regulation.• The trust was not assured it had adequate arrangements in place to meet its safeguarding responsibilities.• We identified risks to patient safety. There were no clear arrangements for out of hours gastrointestinal bleed treatment at Pilgrim Hospital.• We were not assured all incidents were reported; not were we assured that they were investigated in a timely way.• We received a mixed picture regarding staff receiving feedback from incidents. Some areas were able to tell us they received feedback and learning through email and staff meetings. In other areas, staff did not feel they received feedback.• We were not assured actions identified from root cause analysis investigations were being implemented to improve the safety of care being provided.• Medicines related incidents were the second highest number of incidents reported in the trust. Between July to September 2016, omitted medicines accounted for 36% of all incidents reported in the trust. Of these 84 omissions related to critical medicines where there was a significant risk of harm if these medicines were delayed or omitted. This corresponded with data collected during the inspection week. <p>However:</p> <ul style="list-style-type: none">• We found staff knew how to report incidents through the trusts electronic incident reporting system.	<p>Inadequate </p>

Summary of findings

- The trust used a nationally recognised staffing tool for to determine nursing staffing levels alongside patient acuity and dependency. We were told this was also used in conjunction with professional judgement principles.
- The proportion of consultants reported to be working at the trust was about the same as the England average. The proportion of junior doctors (foundation years one and two) reported to be working at the trust was higher than the England average.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust had a Duty of Candour policy in place. The trust told us staff received training on the duty as part of serious incident investigation training. The trust told us they had implemented three levels of training on the Duty of Candour, but they did not provide further information to demonstrate the numbers of staff this had been delivered to.
- Generally we found staff knew about the importance of being open with patients when things went wrong.
- Minutes from the trust's quality governance committee meeting dated June 2016 stated the committee was not assured the trust was meeting the obligations of the duty of candour requirements and asked for this to be placed on the trust's risk register. This was reported through the Quality Governance Committee "Upward Report to the Trust Board" in July 2016. We reviewed the minutes of the July, September, October and November 2016 Trust board meetings but we did not find any evidence that there was any further discussion about this lack of assurance or how the trust were addressing this. We reviewed the minutes of the September 2016 QGC and found evidence that it had been discussed at that meeting and a plan was being developed.
- During the inspection, we reviewed four root cause analyses (RCAs) from serious incidents. Three occurred after the duty of candour regulation came into force for the NHS. The RCAs contained a section relating to the trust's duty of candour obligations; not all parts in the RCA's reviewed had been completed.

Safeguarding

Summary of findings

- The trust had appropriate safeguarding policies and procedures in place for both adults and children.
- The executive lead for safeguarding both adults and children was the Chief Nurse. In addition there were a team of safeguarding leads for both adults and children which comprised of a deputy chief nurse, named professionals for both safeguarding adults and children and young people. A named midwife and doctor were also in place. In addition there were two safeguarding practitioners in post and two administrative staff to support the safeguarding team.
- A safeguarding committee was in place which reported to the Integrated Governance Committee (IGC) and then to the trust board.
- The trust had a Safeguarding Statement of Intent on their website which was dated September 2016. The statement indicated the trusts Safeguarding Committee was ensuring all the trusts responsibilities were met.
- In July 2016 the board was informed that the IGC had not considered there to be adequate assurance in respect of the safeguarding agenda across the trust. There were issues in respect of the Safeguarding Committee and a review had been initiated. The Board was advised that the IGC would continue to monitor the situation and provide updates through the assurance report to Board.
- We reviewed copies of the minutes of the trust board and the IGC meetings for July, August, September, October and November 2016. In July, the IGC reported that an external peer review was reviewing the governance arrangements and a report was likely in September 2016. There was no evidence that the findings of this review had been reported back to the board through the reporting structure.
- We were not assured that the trust board were adequately sighted on the progress being made to ensure the trust met statutory obligations.
- The trust set a mandatory target of 95% for completion of safeguarding training. In October 2016 trust wide safeguarding compliance for level 1 safeguarding children was 89% and level two 80%. Level 3 safeguarding children's training was 81% for 3a and 73% for level 3b. Safeguarding adult's level 1 was 89% and 80% for level 2.

Incidents

- An incident reporting policy was available to staff. Incidents, accidents and near misses were reported through the trust's electronic reporting system. Between 1 August 2015 and 31 July 2016 11,536 incidents had been placed on the system. This

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included all the specialisms at Pilgrim and Lincoln and the emergency department at Grantham. The highest number related to medical services at Pilgrim and Lincoln (5930 in total) and the lowest was the emergency departments across Lincoln, Pilgrim and Grantham (242 in total).

- Analysis showed the greatest number of incidents related to accidents which may result in personal injury (1,623 on medical wards). The second highest number related to medicines (1,623 on medical wards) and the third related to treatment and procedures including pressure ulcers and infection control (446 on medical wards).
- We found staff knew how to report incidents through the trusts electronic incident reporting system.
- We received a mixed picture regarding staff receiving feedback from incidents. Some areas were able to tell us they received feedback and learning through email and staff meetings. In other areas, staff did not feel they received feedback.
- In accordance with the Serious Incident Framework 2015, the trust reported 72 serious incidents (SIs) which met the reporting criteria set by NHS England between August 2015 and July 2016. Of these, the most common type of incident reported were pressure ulcers meeting SI criteria (35% of all incidents).
- All severe incidents and deaths were reviewed at a weekly meeting and a decision on whether the incident qualified as a serious incident was made by the trust's risk team with input from the Medical Director and Chief Nurse. However, we found evidence that the trust was not reporting incidents onto the National Reporting and Learning System within the required timescales. The Commissioners were taking action with the trust to address this.
- Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide systematic protective barriers are available at a national level, and should have been implemented by all healthcare professionals. The trust had declared three never events between August 2015 and July 2016 all of which related to surgical care.
- Investigations were undertaken for all serious incidents by an appropriate clinician who was determined by the Medical Director and Chief Nurse.
- Falls resulting in injury and pressure ulcers graded three and four were reviewed by a panel of clinical staff chaired by a deputy chief nurse. The review process was robust with lessons

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learned and actions to mitigate further risks documented. However, because of the number incidents waiting to go through the process, delays could amount too many months before a review would take place.

- We reviewed three serious incidents at random to track and see if lessons had been learned. Two related to hospital acquired pressure ulcers; one of Grade 3 and another of Grade 4. The third incident related to the death of a patient following an elective procedure. All incidents had been investigated appropriately.
- Actions had been taken for the death of the patient and staff had undertaken further assessments of competence. Learning points had been shared across appropriate areas of the trust and deadlines met for the actions.
- Five actions were in place for one of the pressure ulcer incidents (March 2016) although no dates for completion of the actions were in evidence in the action plan. In September 2016, skin risk assessment documentation was in place for 71% of patients on admission or transfer to another area. Trust policy stated all patients should have one in place.
- The deadline for completion of the six actions relating to the second pressure ulcer was 30 September 2016; two weeks prior to our inspection. We found some actions had been undertaken including increasing the numbers of nurses and the identification of patients who were at high risk of developing pressure ulcers. Another action was to implement hourly rounding. Hourly rounding is a structured process where nurses on wards in acute and community hospitals carry out regular checks with individual patients at set intervals, typically hourly.
- We looked at a total of four hourly rounding charts on the ward where the pressure ulcer had been identified. We found three had gaps of between three hours and eight hours and 20 minutes between checks. One chart had nothing documented for the day we visited. We were therefore not assured that the hourly rounding action had been embedded and there were potential missed opportunities to keep patients safe. Staff informed us they did not have the time to undertake hourly rounding for all patients.

Medicines

- The trust used a paper based system for medicine administration charts across all sites. A business case had been submitted to implement electronic prescribing to reduce risk of errors and improve efficiencies.

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- The trust provided a pharmacy service across all three sites to most wards with the potential for both a pharmacist and a technician to visit each ward although this did not happen on a daily basis.
- The pharmacy team told us they felt they were ‘spread thinly’ and almost universally told us they did not have enough time to spend on wards. Timings for the visits were strictly allocated and we were told these were not generally flexible to allow for differing demands at different times on wards.
- Nursing staff told us medication administration charts had to leave the wards for long periods for medicines to be obtained from pharmacy. This resulted in patients’ medicines being delayed or missed and meant the charts were not available for medical staff to review treatments.
- Medical staff did not always indicate that a chart had been reviewed in line with trust policy and we were told the absence of the chart from the ward was a contributing factor.
- Discharges were sometimes delayed due to delays in obtaining the correct medication for a patient to take home. Delays occurred most commonly where the patient required their medicines blister packed and where the medicines listed on the electronic discharge document (eDD) were different from those on the administration chart. Data collected by the pharmacy team demonstrated there was a discrepancy rate of up to 24% between the medicines charts and the eDDs. All of the pharmacists we spoke to and four of the ward staff told us pharmacists were not supported to check the eDDs as this was not felt to be an effective use of their time. Staff on the wards acknowledged this would prevent many of the errors that were subsequently identified and remedied by the nursing staff.
- We heard concerns from patients, relatives and staff about the delays getting discharge medication.
- The Medical Director told us the process of pharmacists not having involvement in checking eDDs was supported by hospital clinical management as a strategy to improve the focus of the pharmacy team on medicines reconciliation. This would ensure medicines were correct on the administration sheets which should then translate into the eDDs. Information from external stakeholders supported concerns raised within the trust about accuracy of discharge medicines and the information disseminated to primary care providers.
- Senior pharmacy staff told us the trust had achieved 80% of medicine reconciliations completed on admission within 24hrs. (Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing

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the medical record to an external list of medications obtained from a patient, or GP). From our investigations on the wards it was identified that reconciliation was occurring but it was not clear the 24 hour target was being met. Analysis of medicine reconciliation data provided by the trust for August 2016 demonstrated that 19 wards out of a total of 32 we were given information for had not met the trust's 80% target. Overall the reconciliation within 24hrs rate was 75% which is in line with national figures. However some wards were as low as 20% and we did not have data for all of the wards.

- Medicines related incidents were the second highest number of incidents reported in the trust. Between July to September 2016, omitted medicines accounted for 36% of all incidents reported in the trust. Of these 84 omissions related to critical medicines where there was a significant risk of harm if these medicines were delayed or omitted. This corresponded with data collected during the inspection week.
- All staff we spoke to explained the process for reporting and investigating medicine incidents and described awareness of recent incidents within the trust demonstrating that learning from incidents was shared.
- We identified on five wards we visited fridge temperatures were not recorded correctly; either single daily temperature readings were recorded rather than maximum and minimum levels or temperatures were not recorded on a daily basis. This did not demonstrate a consistent temperature had been maintained to assure the safety and efficacy of the medicines. This was highlighted at ward level where it was observed.

Staffing

- Staffing was one of the trusts strategic risks. There were three key performance indicators for the trust relating to staffing, these were to reduce reliance on agency staff, ensure that nursing shifts are filled with the appropriate level of staff and to reduce vacancy rates.
- The trust were recruiting nurses from overseas although there had been some difficulties with this. The trust also faced challenges retaining overseas nurses. This was particularly problematic at Pilgrim Hospital which is in a much more rural area near the East coast.
- The trust used a nationally recognised staffing tool for to determine nursing staffing levels alongside patient acuity and dependency. We were told this was also used in conjunction with professional judgement principles. Acuity is the level of the condition of a patient.

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- The patient acuity and dependency scores were collected daily and the senior nursing teams confirmed this data at the site operational meetings held throughout the day.
- A monthly staffing report was presented to the trust board. The report provided tables and information but not all of the data in tables was clearly explained. For example, the tables on current vacancy levels had no accompanying narrative.
- Average fill rates across the trust were 88% for registered nurses and midwives and 99% for care staff during the day. At night the average fill rate of registered nurses and midwives was 96% and 98% for care staff. Fill rates had remained fairly static. When broken down by hospital site, the fill rates for registered nurses and midwives at Pilgrim Hospital during the day were lower at 85%, compared with 91% at Lincoln County Hospital.
- In an attempt to reduce agency staff, the trust was offering incentive packages for bank working.
- We heard from nursing staff that they felt the high number of agency staff being used in some reads was impacting on staff morale and the delivery of high quality care. From April 2015 to March 2016 the trust had a bank and agency useage rate of 11%, at Lincoln Hospital the rate was 12% and at Pilgrim Hospital it was 11%. We looked at the Staffing report to the trust board but there was no narrative to explain the nurse agency useage.
- In June 2016 the trust reported an average turnover rate of 9% for nursing and midwifery staff trust wide. This was broken down to a turnover rate of 9% at Lincoln County Hospital and 8% at Pilgrim Hospital.
- There were a number of initiatives in place to aid the retention of nursing staff, including; The implementation of the incentive packages to encourage more staff to join and work for the trust own nurse bank; The release of the 'Key to Care' initiative which is a support package for agency nurses and single contracted bank staff who work within the trust. This included regular contact and updates through a variety of media settings, induction and information packs as well as an accreditation scheme whereby they can accrue 'tokens' through continued working in the trust. The tokens could then be used to access in-house training events.
- The trust had been successful in its bid to become a pilot site for associate nurses.
- As at June 2016 the trust reported an average vacancy rate of 20% for medical and dental staff. Vacancy rates were higher at Lincoln County Hospital with a 24% rate compared with 12% at Pilgrim Hospital.

Summary of findings

- The average turnover rate for medical staff was 48%. The medical staff sickness rate was slightly lower than 2%.
- Between April 2015 to March 2016 the trust had a bank and locum rate of 21%.
- The proportion of consultants reported to be working at the trust was about the same as the England average. The proportion of junior doctors (foundation years one and two) reported to be working at the trust was higher than the England average.

Major incident awareness and training

- There were not robust arrangements in place to respond to emergencies and major incidents. A major incident plan and action cards were available but were not in date nor were they easily accessible to staff. The purpose of a major incident plan is to provide a framework for the trust to respond in a co-ordinated manner to a major incident or an internal trust declared incident.
- Equipment for use in a major incident had not been checked and some was not in working order.
- Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response could be provided detailing how they were going to address our concerns to minimise the risks to patients. In response the trust provided a detailed plan outlining actions that were to be taken to address our concerns. We saw actions were specific, measurable, achievable, realistic and timely (SMART). During our unannounced inspection we saw our concerns had been rectified.

Assessing and responding to patient risk

- Patients being treated for sepsis were to be treated in line with the 'Sepsis Six Care Bundle', the "Sepsis Six" is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis if given within an appropriate period. There is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour.
- Data provided by the trust for October 2015 to September 2016 showed that on average 50% of patients diagnosed with sepsis were receiving antibiotics within one hour, however compliance varied month to month with the lowest compliance at 15.7% (October 2015) and highest 75% (December 2015). We looked at patient records across the trust and reviewed the care and

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treatment being given to patients with suspected sepsis. Whilst we found compliance was generally good in relation to patients being screened for sepsis, performance in relation to the number of patients getting antibiotics within one hour required significant improvement.

- During our inspection, we met with the quality and safety manager and associate medical director who were the overall leads for sepsis management throughout the trust to discuss their plans to improve performance on the management of sepsis. There were plans in place to improve performance across the trust. This included sepsis boxes in all areas, the introduction of a patient group direction (PGD) for intravenous meropenem (a broad-spectrum injectable antibiotic used to treat a wide variety of infections), recruitment of two full-time sepsis nurses, working in partnership with a local NHS ambulance provider and the roll-out of an electronic learning package. The quality and safety manager and associate medical director told us they were confident there would be an improvement in sepsis management and treatment within six months of our inspection.
- We formally wrote to the trust notifying them of our concerns relating to the trust wide sepsis performance. We asked the trust to tell us how they were going to address our concerns to minimise risk to patients. In response, the trust provided an action plan setting out how they would address the concerns. We were satisfied the trust had an action plan in place which included areas that were known to improve performance. We agreed to monitor the trusts performance with sepsis management alongside NHS Improvement.
- During our inspection, staff raised concerns about the lack of an out of hours Gastrointestinal (GI) bleed rota at Pilgrim Hospital
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance for Gastrointestinal Haemorrhage: Time to Get Control (2015) states there must be a GI rota to provide treatment anytime of the day or night, either on-site or as part of an agreement within a network of providers. There was no on call GI bleed rota at Pilgrim hospital. A GI bleed is all forms of bleeding in the digestive tract. Depending on the severity, these can lead to significant blood loss over a short period. This was a known risk but was not included on the risk register. The hospital was unable to provide this cover due to medical staffing constraints.

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- There were guidelines were available (review due December 2016) for the management of patients with upper gastro-intestinal bleeding however, staff did not demonstrate a consistent awareness of these and were not clear about the care of patients who may have a GI bleed out of hours.
- We formally wrote to the trust notifying them of our concerns relating to not having a GI bleed rota. We asked the trust to tell us how they were going to address our concerns to minimise risk to patients. In response, the trust provided an action plan setting out how they would address the concerns. The action plan did not set out clear steps as to how they were going to manage this risk in a timely way so we asked the trust to consider further action. Following this we were satisfied the trust had taken sufficient action to manage the current risk because they had implemented a transfer protocol agreed between physicians on all sites. We were not assured that there were agreements in place with the ambulance service to transfer and divert patients to Lincoln County Hospital. In December 2016, the trust told us they were working to address this.

Are services at this trust effective?

We rated effective as requires improvement because:

- Whilst Information about patient's care and treatment, and their outcomes, was routinely collected and monitored, outcomes for patients were sometimes below expectations when compared with similar services at a national level.
- There were no protocols in place for the management and manipulation of fractures or fractured neck of femur (a crack or break in the top of the thigh bone).
- The trust used a maternity dashboard but the data was not rated to enable themes and trends or benchmarking comparisons to be easily made.
- There was no policy for restraining patients. The trust did not consistently record the numbers of patients who had received rapid tranquilisation medication or recorded any episodes of restraint of patients.

However:

- Procedures, policies and clinical guidelines were easily accessible through the trust's intranet. Generally we found policies and procedures and clinical guidelines were up to date and reflected national guidance.

Requires improvement



Summary of findings

- Care pathways; multidisciplinary plans of anticipated care and timeframes were in place for specific conditions or sets of symptoms.
- Both of the hospitals endoscopy departments were Joint Advisory Group (JAG) accredited.
- Mortality Review Assurance Group (MoRAG) meetings were held monthly across all medical specialties to discuss patient deaths.
- Between April 2015 and March 2016, 60% of babies were born normally, which was the same as the England average. In the same period trust wide, caesarean section figures were the same as the England average at 26%.
- The trust submitted data to the sentinel stroke national audit programme (SSNAP) Lincoln County Hospital achieved grade B SSNAP level and Pilgrim hospital was rated as level C.
- Between February 2015 and January 2016, medical patients at the trust had a lower than expected risk of readmission for non-elective and elective admissions.

Evidence based care and treatment

- Care pathways; multidisciplinary plans of anticipated care and timeframes were in place for specific conditions or sets of symptoms. Pathways were in line with national guidance and included for example, pathways for sepsis, stroke, acute kidney injury, venous thromboembolism (the formation of blood clots in the vein), asthma, urinary catheter care (urinary catheters are hollow tubes that collect urine from the bladder) and peripheral venous catheters (a small, flexible tube placed into a peripheral vein in order to administer medication or fluids). Not all pathways were being followed, for example, patients were not getting antibiotics within one hour as per the sepsis pathway.
- Whilst Information about patient's care and treatment, and their outcomes, was routinely collected and monitored, outcomes for patients were sometimes below expectations when compared with similar services at a national level. For example, results in the 2014 to 2015 Heart Failure Audit were below the England and Wales average for all 10 out of the 11 standard. The 2013 to 2014 myocardial ischaemia national audit project (MINAP) results showed the hospital performed worse than the England average for the three indicators. In addition, the 2015 National Diabetes Inpatient Audit (NaDIA) there were 15 scores worse than the England average. The trust were aware of the short falls and were working to address these.

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- There were no protocols in place for the management and manipulation of fractures or fractured neck of femur (a crack or break in the top of the thigh bone). This did not meet national guidance and meant there was a risk that patients requiring manipulation of fractures or who had experienced a fractured neck of femur may be mismanaged.
- In January 2016 the Royal College of Emergency Medicine (RCEM) launched the CLEAR Campaign. CLEAR is a five point plan to improve emergency mental health care. As part of this plan RCEM recommends a patient who is experiencing mental distress should be seen within one hour of referral to mental health services. A mental health liaison team (MHLT), provided by a neighbouring NHS mental health trust was accessible to the Emergency Department (ED) 24 hours a day, seven days a week. Four out of seven adults presenting to the department during our inspection did not have a review by the MHLT within one hour of arrival, one did not have a review time recorded and one patient self-discharged before being reviewed. Whilst awaiting a review by the MHLT there were no further resources to support healthcare professionals in caring for this group of patients. For example, the trust did not have a policy for the assessment, management and care of adult patients who attended the ED due to self-harming behaviours or suicidal intent, nor had staff received training regarding their responsibilities in line with legislation and guidance, including The Mental Health Act (1983). The Mental Health Act governs the involuntary admission and treatment of persons with mental disorders. It provides criteria for their rights notification, second medical opinions, renewal certificates, review panels, and other related issues.
- Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response could be provided detailing how they were going to address our concerns to minimise risk to patients. In response the trust provided a detailed plan outlining actions that were to be taken to address our concerns. Actions included developing a clinical guideline regarding the care and treatment of patients with mental health conditions and contacting a local NHS provider of mental health services to request assistance in developing a training package for the ED staff regarding the care of the mental health patient.
- In April 2016, Lincoln County hospital and Pilgrim Hospital's endoscopy departments had a Joint Advisory Group (JAG)

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status of 'Assessed: Criteria met'. JAG accreditation is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training.

- The care of women using the services was in line with Royal College of Obstetrics and Gynaecology (RCOG) guidelines (including '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.
- Within the trust, guidelines for electronic fetal monitoring had been delayed following a NICE surveillance review of Intrapartum Care CG190. The group had decided not to ratify the new guidelines until rerelease by NICE in November 2016. However, there was not an addendum on the current guidelines highlighting this decision. This meant the trust was using the older guidance without an explanation why. This could cause confusion for staff classifying intrapartum cardiotocographs (CTGs).
- There was an evidence based delirium care pathway for frail adults, a pathway for the management of behaviour and psychiatric symptoms of dementia and a pathway for the administration of rapid tranquilisation. However, the trust did not follow national guidance for the administration of rapid tranquilisation medication. We reviewed the care records for a patient who had received a rapid tranquilisation injection on three occasions but could not see evidence within the patient's records that the patient's vital signs had been monitored or that a full incident review had taken place within 72 hours. This did not follow National Institute for Health and Care Excellence (NICE) guidance interventions for the management of disturbed/violent behaviour. In addition, it did not meet the recommendations of the patient safety alert, the importance of vital signs during and after restrictive interventions and manual restraint. Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response could be provided detailing how they were going to address our concerns to minimise risk to patients. In response the trust provided a detailed plan outlining actions that were to be taken.

Patient outcomes

- The trust's 'rolling 12 month' Hospital Standardised Mortality Ratio (HSMR) for April 2015 to March 2016 was 101.5, which had

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decreased (was better) from the previous year of 109. Hospital standardised mortality ratios (HSMRs) are intended as an overall measure of deaths in hospital. High ratios of greater than 100 may suggest potential problems with quality of care.

- The latest published Summary Hospital-level Mortality Indicator (SHMI) for July 2015 to June 2016 was 1.10 which was as expected. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.
- The trust had one active mortality outlier alert as at 6 September 2016 for septicaemia (except in labour). The trust were reviewing this outlier to identify any areas for improvement. Their response to the alert would then be reviewed by the Care Quality Commission.
- Mortality Review Assurance Group (MoRAG) meetings were held monthly across all medical specialties to discuss patient deaths. These were also known as mortality and morbidity meetings and give health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. Minutes from the meetings (April 2016, May 2016 and June 2016) showed mortality reviews had taken place with evidence of shared learning and actions identified where appropriate.
- The trust submitted data to the sentinel stroke national audit programme (SSNAP) which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. Lincoln County Hospital achieved grade B SSNAP level in the latest audit, which covered January 2016 and March 2016. Lincoln County Hospital was performing better than the previous quarter when it was graded as level D. Pilgrim Hospital achieved grade C SSNAP level in the latest audit, Pilgrim Hospital was performing worse than the previous quarter when it was graded as B overall. The results are given on a scale of A to E, with A being the best score and E the lowest.
- The trust provided a 24 hour stroke thrombolysis service (this is a treatment where medicines are given rapidly to dissolve blood clots in the brain).
- The trust took part in the 2015 National Diabetes Inpatient Audit (NaDIA). Results showed Pilgrim Hospital had two scores better than, and 15 scores worse than, the England average. Results for Lincoln County hospital had three scores better than and 14 scores worse than the England average. Of note, the multidisciplinary foot care team (MDFT) saw no patients within

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24 hours, which was much worse than the hospital's previous result of 57% and the England average of 58%. The hospital also had a high percentage of management errors. The trust demonstrated a deteriorating performance against their previous results. We saw the trust had an action plan to address the areas where scores were below the England average.

- Lincoln County Hospital took part in the 2013/14 myocardial ischaemia national audit project (MINAP). The hospital performed better than the England average for the three indicators. Lincoln County Hospital saw improvements from the 2012/13 audit in two of the indicators.
- Monthly monitoring of dementia screening was undertaken as part of the National Dementia Commissioning for Quality and Innovation (CQUIN). The CQUIN payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. Data for the reporting period July 2016 to September 2016 showed between 96.57% and 99.53% of patients were screened for dementia.
- Between March 2015 and February 2016 the average length of stay for medical elective patients at the Lincoln County Hospital was lower than the England average (3.3 days, compared to the England average of 3.9). For medical non-elective patients, the average length of stay was higher than the England average, (7.3 days, compared to the England average of 6.7 days). At Pilgrim Hospital, the average length of stay for medical elective patients at Pilgrim hospital was significantly lower than the England average (1.8 days, compared to 3.9 days for the England average). For medical non-elective patients, the average length of stay was about the same as the England average (6.8 days, compared to 6.7 for the England average).
- Between February 2015 and January 2016, medical patients at the trust had a lower than expected risk of readmission for non-elective and elective admissions.
- The trust used a maternity dashboard as recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) (2008). Monthly figures of clinical outcomes before, during, and after delivery were collected and reported jointly on across both Lincoln County Hospital and Pilgrim Hospital. This is thought to help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care. The RCOG guidance states 'Individual maternity units should set local goals for each of the parameters monitored, as well as upper and lower thresholds'. The data received from the trust did not have red, amber, green (RAG) ratings on it. This meant

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that staff could not assess the data against trust targets. There could be the risk that staff would lose oversight of the risks. For example, the trust wide rate of failed instrumental (assisted) deliveries that resulted in emergency sections peaked at 11.4% in January 2016, but stayed between one and six percent for the next six months. The lack of RAG rating meant the peak was not highlighted. Staff told us that the data had only been collected for a few months and they were not familiar with both the collection and the patient outcomes. However, information provided by the trust included eight months of trust wide data.

- Trust wide, between April 2015 and March 2016, 60% of babies were born normally, which was the same as the England average. In the same period trust wide, caesarean section figures were the same as the England average at 26%.

Multidisciplinary working

- There was effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment.
- There was daily communication between multidisciplinary teams across the trust.
- Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks and concerns.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- There was a policy for consent to examination to treatment (review 2018) available for staff to access on the trust's intranet system. The trust also provided evidence of a pathway (no date of review) available to staff for assessing consent and capacity: meeting legal and regulatory requirements for patients aged 16 years and over.
- The trust's target for training on Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was 95% and was incorporated into the safeguarding adults training. Latest figure of compliance for MCA training provided by the trust was 76% for October 2016, which did not meet the trust target of 95%.
- Staff had some understanding of the MCA 2005 and consent. We saw consent to care and treatment was mostly obtained in line with legislation and guidance, including the MCA and patients were supported to make decisions. However, one patient had received treatment without a mental capacity assessment or DoL's application in place.

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- DoLS are a set of checks that aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests. Between September 2015 and September 2016, there had been 43 applications for DoLS across the medical wards at this hospital. However, the trust had not informed the Care Quality Commission (CQC) about any of these applications. This meant the trust had not been reporting these applications in line with Regulation 18 of the Health and Social Care Act 2008 (Registrations) Regulations 2014.
- Wards 6A and 6B at Pilgrim Hospital and Dixon ward at Lincoln County Hospital were wards with restricted access, which meant that patients had to ask a member of staff to open the doors. There was no button that patients could press for the door to release. Patients relied on nursing staff to enable them to leave the ward. We requested the policy for locked wards but there was no policy in place.
- Staff used a scoping tool designed to assist in the identification of those patients who may require a formal DoLS referral. Staff did not consider the locked doors as depriving a person of their liberty.
- A 'do not resuscitate cardio pulmonary resuscitation' (DNACPR) order is a documented decision to provide immediate guidance to those present on the best action to take should the person experience a cardiac arrest.
- We looked at three DNACPR orders at Pilgrim hospital and found there were inaccuracies in both forms in how they were completed. Two of the forms had not included a mental capacity assessment for those deemed to lack capacity. We discussed our findings with the nurse in charge who said they would address our concerns. The other form indicated a discussion had taken place with the patient but there was no record of the discussion that took place. We escalated this to the nurse in charge who told us they would speak with the doctor about this.
- The DNACPR orders were at the front of the notes, allowing easy access in an emergency and were recorded on a standard form with a red border. All three of the DNACPR forms were easy to read.
- There was no policy for restraining patients. The trust did not consistently record the numbers of patients who had received rapid tranquilisation medication or recorded any episodes of restraint of patients. However, data was provided of a record of physical interventions for October 2015 to October 2016 which demonstrated 35 occasions when restraint was used which included the name of the clinical lead authorising physical intervention, the time it was applied, type of restraint used,

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time restraint ended, people in attendance, patient name, ward, date, time and incident number. None of the incidents were reported at Pilgrim Hospital, all 35 were reported at Lincoln County hospital, however, we found evidence that patients were being restrained at Pilgrim Hospital.

Are services at this trust caring?

We rated caring as good overall but caring in the medical service at Pilgrim Hospital was rated as inadequate because:

- In most of the areas we inspected staff responded compassionately when patients required help and supported patients emotionally.
- Generally staff interacted positively with patients and we observed that patients were treated with kindness, dignity, respect and compassion while they receive care and treatment. Feedback from patients was mostly positive about the care and treatment they had received.
- The trust had introduced a carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carers badge encouraged carer involvement, particularly for patients with additional support needs.

However:

- We observed instances at Pilgrim Hospital where staff had not treated patients with dignity, respect and compassion.
- The trust's Friends and Family Test performance was generally worse than the England Average between October 2015 and September 2016. In the latest period, September 2016, the trusts performance was worse than the England average (91% compared to an England average of 96%).
- In the Cancer Patient Experience Survey 2015 the trust was not in the top 20% of trusts for any of the 50 questions, in the middle 60% for 40 questions and in the bottom 20% for 10 questions.
- At times, staff focused on the task instead of the patients as individuals. Staff were providing one to one support for some patients as they had been assessed as being at increased risk. However, when providing one to one support, staff did not always engage with patients meaningfully.

Good



Summary of findings

- Within the chemotherapy suite, we noted conditions were cramped and privacy was not afforded to patients receiving chemotherapy treatment. Apart from a space for young people and a space with a bed for patients who felt unwell, there were no privacy curtains.

Compassionate care

- The trust's Friends and Family Test performance was generally worse than the England Average between October 2015 and September 2016. In the latest period, September 2016, the trusts performance was worse than the England average (91% compared to an England average of 96%).
- In the Cancer Patient Experience Survey 2015 the trust was not in the top 20% of trusts for any of the 50 questions, in the middle 60% for 40 questions and in the bottom 20% for 10 questions.
- The trust performed worse than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to Cleanliness, Food, Privacy/dignity/wellbeing and Facilities. Performance had slightly improved in 2016 compared to 2015 for Cleanliness, Food and Facilities but had worsened for Privacy/dignity/wellbeing.
- We spoke with patients and relatives during our inspection. Feedback from patients was mainly positive
- Two out of the eight relatives we spoke with at Pilgrim Hospital were unhappy about the care their relative had received; these related to delayed diagnosis, not able to reach drinks or the call bell, lack of communication and poor hand hygiene.
- Following the inspection, we received comments from four members of the public/relatives of patients which related to the care being delivered on the medical wards at Pilgrim Hospital.
- During our inspection, we observed most staff to be polite, caring and friendly in their approach to the delivery of patient care. Staff used appropriate language to ensure patients understood what was happening. We saw staff respond compassionately when patients needed help and saw a number of examples of good care. For example, we saw a nurse helping a patient to have a drink by being at their eye level and talking with the patient to ensure the drink was the correct temperature and checked to ensure they had taken enough. Another nurse was reassuring a patient who was upset, allowing the patient to express their concerns. We saw the nurse responded in a caring and compassionate manner.
- However, on ward 6A and ward 6B, we also observed instances

Summary of findings

- We observed three instances where patients had dry and cracked mouths on ward 6B and 6A at Pilgrim Hospital. There were no records to indicate they had been given any mouth care.
- Staff mostly maintained the privacy and dignity of the patients they cared for. However, we observed isolated instances where staff had not taken steps to maintain a patient's privacy and dignity.
- Whilst orientating ourselves to ward 6A, we saw two staff members supporting a female patient onto a set of seated weighing scales. The patient was not sufficiently covered with their nightclothes and staff had not closed the privacy curtains around the patient's bed space. This meant other patients in the bay and any person walking by the bay could see what was happening. On ward 6B, again whilst orientating ourselves to the ward, we saw that staff had not pulled the privacy curtains around a patient's bed space when repositioning the patient in bed. This did not maintain the dignity or privacy of the patient and meant other patients in the bay and anyone passing by the bay could see what was happening. On both occasions we prompted staff to close the curtains.
- We spoke with one relative of a patient who had a learning disability. They raised concerns with us about the lack of compassionate care their relative had received at Lincoln County Hospital, although they felt the care they had received in critical care had been excellent.

Understanding and involvement of patients and those close to them

- The trust performed about the same as other trusts for all twelve questions examined from the CQC Inpatient Survey 2015 which related to understanding and involvement of patients and those close to them.
- Patients told us they generally felt involved in their care.
- The trust had introduced a carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carers badge encouraged carer involvement, particularly for patients with additional support needs. Being signed up to, the carers badge also gave carers free parking whilst they attended at the hospital.

Emotional support

- In the Cancer Patient Experience Survey 2015 the trust was not in the top 20% of trusts for any of the 50 questions, in the middle 60% for 40 questions and in the bottom 20% for 10 questions.

Summary of findings

- Throughout the trust, there was no psychologist support for patients who had experienced a stroke. Staff on the stroke ward told us this service was available in the community, however there was a criteria for patients to be mobile to access this support. This meant there could be some patients who had experienced a stroke who were not able to access the psychological support they required. However, we saw a clinical nurse specialist for stroke services supporting a patient who had suffered a stroke.
- There was a trust wide chaplaincy service; we saw this advertised on notice boards within the wards and we spoke with one of the chaplains. The chaplaincy team provided an on call service, which was also available out of hours. They provided support and assistance to patients to contact local spiritual or religious priest or ministers.
- Clinical nurse specialists were available for advice and support in a number of specialties including stroke services, cancer services and for care of the older person. The hospital Macmillan nursing team offered counselling and support to patients and staff on the oncology ward.
- Patients informed us staff tried their best to make the hospital environment as normal as possible and we observed a number of patients had personal belongings with them such as photographs.
- A volunteer from the Alzheimer society attended the ward to offer support to relatives and carers.
- We were told there was a mental health liaison team was available 24 hours a day seven days a week for support, assistance and information.
- We were told there was a dementia practitioner available to talk with and support patients and their carers who were living with dementia.

Are services at this trust responsive?

We rated responsive as requires improvement because:

- Patients had been unable to access services in a timely way for an initial assessment, diagnosis or treatment including when cancer was suspected. During 2016 the trust has failed to meet the majority of the national standards for the cancer referral to treatment targets
- The trust had failed to meet the national standard for the referral to treatment time for incomplete pathways for the previous three consecutive months.

Requires improvement



Summary of findings

- There were significant delays in patients receiving their follow up outpatient appointment across several specialities with 3,772 appointments being overdue by more than six weeks.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England overall performance between October 2015 and October 2016.
- The trust reported a high number of bed moves (40%) over 11 months, 595 of which occurred after 10pm within a six-month reporting period.
- Systems were not robust to identify vulnerable patient groups which included patients living with dementia and patients with learning disabilities.
- Although there had been improvements in the management of complaints within the trust since our last inspection, the response times were still not in line with the trusts policy.

However:

- The trusts bed occupancy rate was similar to the England average for Quarters 1 to 3 2015/2016 and below the England average for Q4 2015/2016.
- Site management meetings took place three times each day in the hospitals. These meetings were used to identify the number of available beds, patients who needed admission, were awaiting discharge or were on outlying Wards.
- The chaplain teams represented a range of faiths and provided support across all beliefs. Bereavement services were also provided within the chaplaincy service. The team provided a range of specific services including hospital funerals, weddings, birth and death sacraments, memorial services, worship and Holy Communion.

Service planning and delivery to meet the needs of local people

- Between June 2015 and May 2016, the main reasons for delayed transfer of care at the trust were Completion of Assessment (33%), followed by Waiting further for NHS Non-Acute Care (27%).
- The trusts bed occupancy rate was similar to the England average for Quarters 1 to 3 2015/2016 and below the England average for Q4 2015/2016.
- Due to the lack of medical staff in the emergency departments (ED) at Pilgrim and Lincoln hospital the trust had made a decision to close the ED at Grantham overnight for a proposed period of three months. This happened in August 2016. There had been no consultation with local people. At the time of the

Summary of findings

inspection there were ongoing concerns being raised by the public about the overnight closure however the trust did not have enough medical staff to be able to provide a safe service in Grantham.

- The Grantham ED was open from 9am to 6.30pm seven days per week. Although this was displayed on the trust website, on the ED main doors and on the main sign to the hospital, patients were still presenting to the department prior to and after the closure. Staff were auditing this. Between 30 September 2016 and 21 October 2016 on average, six patients were waiting outside the department prior to the 9am opening. In the same period, on average, five patients presented to the department at 6.30pm.

Meeting people's individual needs

- There was no electronic system in place for identifying patients with a learning disability at the trust.
- We did not see any evidence of how the trust measured and monitored its performance in relation to meeting the needs of patients who had a learning disability.
- There were two learning disability specialist nurses employed by a neighbouring mental health trust who provided liaison support for the trust. There was an open referral system and the nurse carried a mobile telephone so they could be alerted of the patient's admission. However, we were told the nurse was located 'off site' which could delay how quick they could attend the hospital. Information provided by the trust indicated there was a learning disability care plan, which provided by the learning disability nurse specialist on referral. We did not see any patients with a learning disability on the wards we inspected.
- A relative of a patient who had a learning disability told us they had received care on the general hospital wards at Lincoln County Hospital which was not based on their relative's individual needs. However, they said the care their relative had received in the critical care unit was very good.
- Not every ward area provided a communal day area for patients, for example, Dixon ward at Lincoln County Hospital did not have a day room as this had been taken to accommodate a discharge lounge. This meant patients on this ward had no alternative but to remain by their bed space. In addition, there was no dedicated area for private discussions to take place. We did not see the day rooms on the care of the elderly wards at Pilgrim Hospital in use.

Summary of findings

- Staff had access to interpreting services for patients who did not speak or understand English. The service was provided externally and included the provision of British Sign Language.
- The chaplain teams represented a range of faiths and provided support across all beliefs. Bereavement services were also provided within the chaplaincy service. The team provided a range of specific services including hospital funerals, weddings, birth and death sacraments, memorial services, worship and Holy Communion.
- A quiet room was available for Muslim staff and patients to conduct their prayers. Washing facilities and prayer mats were available for people to use.
- Care of the elderly wards had activity boxes, containing resources for distraction and to provide a stimulation activity for restless hands for patients living with dementia.
- The trust had introduced a carer's badge which enabled any family members and trusted friends to be involved in the care of their loved ones. The carers badge encouraged carer involvement, particularly for patients with additional needs. Family members who qualified for a carers badge also received free parking whilst they attended at the hospital.
- A number of wards displayed information for patients and carers on a variety of topics such as trust information, quality standards, disease/condition specific information, ward/staff contact details, a who's who of staff on the ward and general useful signposting on where to get further information such as complaints and support groups.

Dementia

- There was no electronic system in place for identifying patients living with dementia at the trust.
- A dementia practitioner covered Pilgrim hospital. They visited patients over 75 years of age and attended the admissions unit in line with national dementia screening. They would also hold a caseload of patients living with dementia and visited them across the hospital to support, offer activities and provide enhanced care. There was a dementia care pathway for guidance on interventions to support patients.
- On ward 6B there was a colourful wall used as a themed space for patients. There were orientation notice boards in the patient's bay, which included details of the day, date, weather, season and any celebrations.
- There were yellow pictorial signs in use in many areas of the hospital to help patients living with dementia.
- Staff told us they used the 'This is me' booklet for patients living with dementia. We were told a member of the Alzheimer's

Summary of findings

society helped patients and their relatives to complete it. We saw no evidence of this being used. This booklet is a simple tool people living with dementia can use to inform staff about their needs, preferences, likes, dislikes and interests.

- We did not see any evidence of how the trust measured and monitored its performance in relation to meeting the needs of patients living with dementia.

Access and flow

- Site management meetings took place three times each day in the hospitals. These meetings were used to identify the number of available beds, patients who needed admission, were awaiting discharge or were on outlying Wards. From this information, the site management team made decisions in relation to patient admissions and supported the discharge of patients to make more beds available.
- Staff had access to an operational escalation policy (review 2015) through the staff intranet. The policy supported managers to identify bed capacity issues early. It identified triggers and actions needed to cope with increased demand for services. The policy clearly identified which wards and departments could open up extra beds and the type of staff required to make the ward safe. There were no escalation beds open at the time of our inspection. Escalation beds are beds that are opened when there is no capacity to admit patients within the hospital.
- During our announced and unannounced inspection at this hospital, medical patients were being outlied because there was no bed available for them in their speciality. This was because there was not enough capacity throughout the hospital for patients requiring admission. Medical outliers are patients who receive care on a different speciality ward. The trust had systems in place to monitor medical outliers throughout the hospital. Medical reviews of outliers took place once their consultant had completed the ward round on the ward for which they were responsible.
- Data provided by the trust for the reporting period July 2015 to June 2016 showed 44% of medical patient admissions did not move wards during their hospital stay. However, 56% of patients moved ward on one or more occasions.
- Delays in obtaining tablets to take out (TTO) prescriptions had been identified as delaying discharges and staff attributed this in part to a sporadic pharmacy service to the Wards. In addition, pharmacy staff did not routinely access the electronic discharge documents and this resulted in discrepancies not being identified until medicines had been dispensed.

Summary of findings

- The trust's referral to treatment time (RTT) for non – admitted pathways had been worse than the England overall performance since July 2015. There is no national operational performance standard for this data. A non-admitted pathway is when a patient's wait for their treatment has ended and they have commenced consultant led treatment without being admitted to hospital to receive the treatment.
- At the end of August 2016, there were 2946 patients waiting over 18 weeks on an incomplete pathway, 2033 of these patients were on non-admitted pathways. The trust explained there was an extra 985 patients waiting over 18 weeks at the end of August 2016 compared to the end of May 2016. The trust had received 1,400 more appointment requests than in the previous 12 months, this increasing demand and back log of follow up appointments were impacting on the ability of the trust to provide appointments for new referrals.
- On the week of the inspection the trust provided data on the number of patients who were waiting for a follow up appointments, 7,483 patients were on the waiting list. Of these 3,772 patients were overdue their scheduled appointment date by more than six weeks.
- The trust's overall referral to treatment time (RTT) performance for incomplete pathways for outpatients had met the national standard from April to June 2016. The national standard is 92%. In July the trust achieved 91% this fell to 89% in August and to 88% in September 2016. An incomplete pathway is when a patient has been referred for treatment but at the time the data was collected they had not yet commenced the treatment.
- There are national waiting time standards to ensure cancer services are delivered to patients in a timely and safe timeframe. From January 2016 to September 2016 the trust met between one and five of the national standards for cancer targets each month. There had been no months during 2016 where the trust met all the national cancer referral to treatment standards.
- The national standard for patients who are referred with suspected cancer or who have breast symptoms is for 93% of patients to be seen within two weeks of being referred. In data reported from April to August 2016 the trust had not met this standard, with 81.12% being their lowest performance reported in August. During this month the standard was not met in eight specialities. However September and October 2016 this standard had been met, however even in these months some specialities did not meet the 93% standard.
- During August 2016 the trust only met the two week referral standard for 31% of the patients referred with suspected breast

Summary of findings

cancer and for 26.3% of the patients referred with breast symptoms. This was a significant reduction from previous month where it had achieved the 93% standard. The trust had taken immediate actions to address these delays and in September 2016 both these referral to treatment times for suspected and symptomatic breast referrals had significantly improved to 91.5% and 88.8%.

Learning from complaints and concerns

- The Deputy Chief Nurse was the lead for complaints. Complaints data was reported in the quality governance report to the trust board. The monthly report also included the number of complaints received and the number still open.
- We reviewed the Patient Experience reports to the trust board for August and September 2016. Whilst the reports did contain data on the number of complaints and the response times, there was little evidence presented to the trust board of how the trust was taking action to address the themes and trends in the complaints. However, the trust did hold a bi monthly lessons learnt forum.
- A 'patient experience' item was reported to the trust board which was usually related to a complaint or concern.
- Complaint responses were signed off by one of the trusts executives, usually the chief operating officer or a deputy, but neither the Chief Executive nor the trust Chairman received complaint responses to read and or sign. We noted one of the non-executive directors had raised how assurance was obtained on the quality of complaints responses.
- There had been improvements in the management of complaints within the trust since our last inspection.
- Between June 2015 and May 2016 there were 789 complaints about trust wide services. The trust had taken an average of 91 days to investigate and close complaints which was in excess of their stated timescales in the `complaints policy.
- The trust's complaints policy (2013) was redesigned with the help of roadshows, discussion with complainants and listening events. The procedure gave four distinct timescales in which complaints should be dealt with, ranging from 15 days for extremely simple complaints to 50 days for particularly complex issues. The policy did not state 'working days'. The complaints lead informed us the policy should state 'working days'. This meant complainants could be misled with regard to timescales.
- At the time of our inspection we were informed there was no backlog of complaints. The complaints lead for the trust informed us all complaints were currently being responded to within the 50 day timescale although they hoped to revert back

Summary of findings

to the four distinct timescales at the beginning of 2017. The information on the trusts website about making a complaint stated the complaint response was typically 25 days but could be more depending on its complexity.

- From 1 January 2016 to 7 October 2016, five patients and/or their relatives had contacted CQC in regard to the poor management of their complaint which had exceeded all the trust's timescales for responding.
- In 2013 the trust had a higher number than the England average of complaints taken to the PHSO. At the time of our inspection ten complaints were with the PHSO for review. The PHSO makes final decisions on complaints that have not been resolved by the NHS to the complainant's satisfaction in England.
- The trust had recently commenced a bi-monthly forum to review the effectiveness of complaints handling, actions taken in response to complaints and sharing of good practice throughout the trust.
- Lincoln County Hospital, Pilgrim Hospital Boston and Grantham Hospital had a Patient Advisory Liaison Service (PALS) located in each of the hospitals. The PALS service was available five days a week for patients and relatives to raise issues of concern about care in the hospitals. During the period 30 August 2015 and 1 September 2016, Lincoln County and Pilgrim Hospital Boston received a total of 3,397 concerns; 1,475 at Pilgrim and 1,922 at Lincoln. Of that total, 44 went on to be raised as formal complaints; the remainder were resolved locally by the PALS teams in a timescale ranging from one hour to one month.
- The majority of PALS concerns related to poor communication, outpatient clinic waiting times, and delayed follow-on appointments for outpatient clinics.
- Staff in the PALS offices always attempted to make contact with the person raising the concern by telephone; they felt it made for a better overall experience for the person raising the concerns.

Are services at this trust well-led?

We rated well-led as inadequate because

- We found low levels of staff satisfaction coupled with high levels of stress and work overload. Some staff told us they did not feel respected, valued or appreciated.
- There was a theme in the focus groups and our contacts with staff which centred on staff telling us they perceived they didn't

Inadequate



Summary of findings

feel confident to raise concerns within their work environments. We met with some staff on a one to one basis and talked with other staff in focus groups. Some staff told us they perceived they were being bullied or intimidated.

- Whilst it was isolated to a small number of wards at Pilgrim Hospital, we were not assured that all staff understood the values because we saw care being delivered that was not respectful or compassionate.
- The Friends and Family test scores were lower average when compared with other trusts. The trust was within the 10% of lowest performing Trusts in terms of percentage of patients who would recommend the ward/clinic.
- The trust's sickness levels between April 2015 and February 2016 were higher than the England average.
- There were weaknesses in the trusts governance framework to support the delivery of the trusts vision, strategy and good quality care.
- We were not assured the board were sufficiently sighted on risk.
- The trust did not have systems in place to ensure the Fit and Proper Person regulation was met. We looked at the files of four directors and found the checks made were inconsistent so assurances that directors were fit and proper persons were not in place.
- The trust had failed to respond to the concerns we raised in the 2014 and 2015 CQC inspections in relation to the outpatient service at Lincoln County Hospital.

However:

- The trust had a vision and a set of values and generally staff knew about these.
- In the past two years, the governance arrangements in the maternity service had been strengthened significantly.
- Generally staff knew who the executive team were and felt the Chief Executive was approachable.
- Each hospital had a patient forum which was led by a non-executive director. Patient representatives attended the forums. In addition to this the trust worked with the local Healthwatch to obtain patient feedback.

Vision and strategy

- The trust had a vision in place which was “Working together to provide sustainable high quality patient-centred care for the people of Lincolnshire.”
- The vision was underpinned by a number of values; The delivery and development of our services will be patient-centred; We put patient safety and well-being above everything;

Summary of findings

We measure and continuously improve our standards, striving for excellence at all times; We offer our patients the compassion which we would want for a loved one; We show respect for you and for each other.

- The aims of the trust were to “Meet the expectations of our patients, develop and support our staff, and ensure our services are clinically and financially sustainable.”
- Generally we found staff knew about the vision and the values but we found there were some examples where staff were uncertain about the trusts future. This was more evident at Pilgrim Hospital and tended to centre on staffs perception of what the impact of any service redesign would have on their place of work. There was also a perception by some staff that they felt Pilgrim Hospital was less important to the trust than Lincoln Hospital was.
- The trust had put on different briefing sessions to engage with staff on the vision and strategy of the trust. For example, the chief executive carried out monthly email briefings.
- Whilst it was isolated to a small number of wards at Pilgrim Hospital, we were not assured that all staff understood the values because we saw care being delivered that was not respectful or compassionate.

Governance, risk management and quality measurement

- Many of the staff we spoke with told us they felt there had been improvements in the trust governance processes and many staff told us they felt the hospitals were much safer than they used to be. However, we found there were weaknesses in the trusts governance framework to support the delivery of the trusts vision, strategy and good quality care.
- There was a strategic risk register that identified both strategic and operational risks. We reviewed the strategic risk register which included the actual risk and the control measures. Some of the entries on the register had controls in place to mitigate the risks and there was evidence these had been reviewed. However, there were other risks which had no controls and did not have evidence that the risk had been reviewed. For example, the strategic risk register had a risk of “Staff causing harm/injury whilst providing clinical restraint to vulnerable patients without any training.” The risk was entered onto the register in June 2016 and was reviewed in July 2016 but the mitigating actions said, “TBD.”
- At the time of the inspection, the Trust had put in place a Risk Management Improvement plan to improve the effectiveness of identifying and managing issues across the Trust.

Summary of findings

- Our inspections in 2014 and 2015 had raised concerns about the outpatient service and the backlog of appointments and the performance in relation to referral to treatment times. We also raised concerns about the condition and availability of medical records. This had resulted in an inadequate rating for outpatient services at Lincoln County Hospital in 2015. Despite the trust providing assurance improvements would be made, we did not find evidence of this during our inspection. Neither of these areas of concern were identified on the strategic risk register.
- We were told the trust was implementing a new risk structure and was integrating the Board Assurance Framework (BAF) with the strategic risk register. There was a risk validation group to review the risks and the board would review the six strategic risks monthly but the board could access the whole risk register if they wanted to. We were told that risk management had been improving since the appointment of a Deputy Chief Executive.
- The trust had a risk management policy and risk registers were held at directorate level. Risks were categorised using a matrix based on the likelihood of the risk occurring and the severity of the impact. Not all areas were able to articulate their operational risks or the mitigating actions in place.
- Each speciality held monthly clinical governance meetings. We reviewed the minutes of meetings held by each speciality before our inspection. There was no set agenda for all specialities to follow, and each speciality discussed different topics. We noted some minutes were more in-depth and robust than others. Whilst some specialities discussed a breadth of areas such as incidents, complaints and compliments, audit, clinical effectiveness, best practice, risk register, education and training, other specialities clinical governance minutes were very brief.
- In the maternity and children's service we found the governance arrangements had been strengthened significantly however they were using separate processes for managing risk than the rest of the trust. Dedicated risk management staff had been appointed in all areas to work proactively with wards, audit leads, matrons and policy group to recognise and raise concerns. Our inspection to the maternity service demonstrated improvements had been made to the quality and safety of this service.
- A ward health check dashboard was used to identify areas of concern and monitor quality on the wards. We were told it was used at a confirm and challenge meeting and had led to some areas having an internal risk summit. We saw evidence that this had happened and the process was used to look at concerns

Summary of findings

about staffing levels in one particular ward. This risk was also included on the strategic risk register. However, there were concerns which we identified on some of the wards at Pilgrim Hospital which had not been flagged as part of the ward assurance programme.

- The trust board met monthly and was supported by a number of other assurance committees. The key committee for quality and safety was the Quality Governance Committee, which was chaired by a non-executive director.
- We reviewed the trust board papers for September, October and November 2016. There was evidence that the non-executive directors offered some challenge at the board. This was particularly evident by one non-executive director who regularly asked for more information on assurance and posed reasonable challenge to the board. However, there was little evidence to demonstrate the impact of the challenge.
- We found the trust board were not always making decisions and board business appeared to be conducted at the sub committees. The minutes did not always provide evidence there had been a discussion by the board on the areas of risk that were being reported via the various committees.
- We were not assured the board were sufficiently sighted on risk. For example, at the September 2016 board it was reported the trust had received a Fire Safety Report from the local Fire and Rescue Service. The report to the board states a number of issues had been reported and an action plan was being produced. We saw the Fire Safety Report and it contained a series of significant concerns which put patients and staff at risk of harm. For example, fire doors wedged open and some fire extinguishers were found to be obstructed, out of date, or in need of repair. There was no evidence in the board minutes to demonstrate the severity of this risk had been discussed. This meant we were not assured there had been sufficient opportunities for the board to challenge the assurance processes and why the trusts fire safety processes were not robust. This meant the information that is used to monitor performance or to make decisions was not reliable.
- The trust was forecasting a year to date deficit of £29.7 million in October 2016, compared to plan of £28.7m but it was forecasting to achieve its financial plan. The trusts deficit was one of the highest in England and as their costs rose their productivity reduced. This meant there were significant challenges for the trust to rebalance the business and finance aspect of providing acute care alongside quality and safety.
- There was an Deputy Chief Executive in place who was sighted on risk and quality.

Summary of findings

- In October 2016, the trusts financial improvement plan had delivered £9.2 million in financial efficiencies against a target of £8.7million. All cost improvement plans which required a quality impact assessment were now reviewed by either the nurse or medical director. We were told that up until now nurse staffing had been protected from cost improvement plans, however this was not guaranteed in the coming months.
- In 2015/16 the trust spent £30million on agency staff. They were working to reduce this and although they had reduced it by 25% they failed to meet the target set by NHS Improvement. The challenges were mainly driven by the difficulties in recruiting staff. There had been difficulties recruiting overseas staff and there were significant locum costs as a result of shortages of medical staff.

Leadership of the trust

- The trust had seen repeated changes in executive leadership over recent years. The Chairman was appointed in March 2016 and demonstrated an understanding of the challenges the trust faced. Whilst he felt it was going in the right direction the pace of change needed more focus. The Chairman recognised staff were often insecure about their future and there was more work to do to empower them. He was very supportive of the Chief Executive and they appeared to work well together.
- Some medical staff told us that although they found the turnover of Chief Executives difficult, the current Chief Executive was listening and was approachable.
- Generally staff knew who the executive team were but there were some exceptions. We also found staff working at Pilgrim Hospital were less likely to know who the executive team were. We saw the trust ensured there was at least one member of the executive team on site at Pilgrim Hospital during the working week.
- The Chairman gave us examples of how important it was to him to be visible and to visit different wards and departments.
- The Chief Executive told us he aimed to be as visible as possible and staff told us they could contact him through email. Some staff commented to us they thought the Chief Executives blog was really useful.
- Some of the trusts executives raised with us they felt accountability in the trust needed to be strengthened, with business units, clinical leaders taking more accountability for performance. Our observations concurred with this view. Generally we found parts of the trust were inwardly focused and

Summary of findings

staff often worked functionally rather than as a whole team.

There was not always a sense of trust or accountability towards common goals. There was weak ownership of corporate objectives by the business units and clinical teams.

- The medical director told us about different examples where he had increased accountability for staffs actions or omissions. For example, they had focused on improving compliance with the theatre safety checklists. Compliance was monitored and where staff were failing to comply with guidance they were sent a letter reminding them of their responsibilities. If the problem continued a further letter would be sent out and if it continued the trust would look at taking disciplinary action.
- The trust was led through business units which had a triumvirate leadership team of a clinical director, head of nursing and business manager.
- We saw some examples of poor nursing leadership where ward leaders had not identified and managed risks to patient care.
- The trust had a leadership development programme which was based around behaviours. We were told about 300 managers had attended different aspects of the leadership programme. However, some members of the executive team acknowledged the trust lacked sufficient numbers of experienced leaders who had strong leadership skills. The Chief Executive told us this was one of his priorities.
- We were told relationships with the commissioners had improved and the trust was working well with the CCG. It was felt the work of the Sustainability and Transformation Plans (STP) had been positive in developing relationships. In December 2015, NHS England launched a new approach to help ensure that health and care services were built around the needs of local populations. To do this, every health and care system in England has produced a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years.
- The executive team told us they were working hard on system relationships and although these were good in health, relationships with the local authority were not as strong.
- During and just after the inspection we raised a number of issues with the trust that needed urgent attention. We were impressed with the response of the Chief Nurse. The Chief Nurse had sought as many opportunities as possible to learn from other trusts and implement these to improve patient care.
- Medical staff at Pilgrim and Lincoln County Hospital reported concerns about the lack of job planning. Job planning is carried out by medical staff to produce clarity of expectation for the employer and doctor about the use of time and resources to

Summary of findings

meet individual service objectives. We were told it was variable across departments. We spoke with consultant medical staff during our inspection and whilst there was recognition that some areas did have job plans in place, there was perceived lack of pace to complete job planning and some staff didn't feel it was given sufficient priority. There were also concerns that although there was a trust policy in place, some clinical directors were interpreting the guidance differently.

- The Trust has recognised that historically its job planning processes have not been sufficiently robust. In July 2015, they purchased an electronic job planning system and re-launched job planning guidance in August 2015. The trust told us work was on-going within the Divisions to develop the job planning process with the aim of ensuring robust job plans were in place for all consultants. It was anticipated that this work would be fully completed for the 2018/19 job planning cycle.
- Data from the 2016 staff survey results show an improvement when compared with the 2015 scores. However, the staff survey results remain below the national comparator. The questions in the staff survey which relate to leadership and culture have notably worse results than the national comparator. For example, questions relating to team working, having enough staff, team meetings, support from immediate manager, senior management visibility and involvement, learning from incidents, addressing staff concerns, training in the last 12 months, recommending the trust as a place to work and collection of feedback from patients are all 4% or more less than the national comparator.

Culture within the trust

- Generally we found low levels of staff satisfaction coupled with high levels of stress and work overload. Some staff told us they did not feel respected, valued or appreciated. During our interviews with senior leaders and our review of board and subcommittee minutes, there was recognition that morale was low and staff were feeling undervalued.
- Prior to, and just after this inspection we were contacted by 16 staff members, at both hospital sites, who wanted to tell us about their concerns. In addition we spoke with twelve members of one specific team who wanted to raise concerns with us.
- We held a number of staff focus groups. There was a theme in the focus groups and our contacts with staff which centred on staff telling us they perceived they didn't feel confident to raise

Summary of findings

concerns within their work environments. We met with some staff on a one to one basis and talked with other staff in focus groups. Some staff told us they perceived they were being bullied or intimidated.

- Whilst we did not witness any member of staff being intimidated or bullied during our inspection, staff wanted to talk to us about how they felt. Some staff were upset when they spoke to us because they felt they were under too much pressure. Some nursing staff told us they did not feel able to raise concerns because it was seen as a sign that they couldn't manage. We were also told that staff perceived that middle managers didn't want to hear concerns because of the implications for the trust if they were seen to not be doing well. Some staff told us if they did raise concerns they were told there was nothing that could be done.
- We received a range of comments from medical staff during the inspection that indicated some staff perceived they were being threatened. Junior medical staff reported there could be threats made in order to get results and some of the clinical directors used a passive aggressive approach. There were also some concerns about clinical directors not always being held to account for their practice. However, junior medical staff also acknowledged there were some good clinical directors in the organisation. There was a perception that the trust knew where the problems were but didn't address them.
- Some junior medical staff told us they didn't feel able to speak out. We heard comments such as, "Raise issues and your career is at risk, and if you don't toe the line you will suffer."
- In outpatients, the administrative staff gave examples of not feeling engaged with the trust and raised some concerns about feeling bullied. However, the clinical outpatient staff did not share the same concerns.
- We also met and spoke with nursing, medical and other health care professionals who did feel able to raise concerns and did not report any perceived bullying or intimidation.
- We were made aware of some specific concerns in one department at Lincoln Hospital where staff told us they felt intimidated and bullied. They also felt unable to raise concerns or query why decisions had been taken. We asked the trust executive team to look into the concerns being expressed by this specific group of staff. Following the inspection, the trust informed us they had commissioned an investigation into the concerns. We will review the findings of this investigation when it is complete.
- We spoke with members of the staff side representatives from the different hospital sites. The staff side representatives also

Summary of findings

told us some of their members were reporting they felt bullied and intimidated by middle managers. The staff side members for Pilgrim Hospital told us they had poor relationships with the middle managers in the trust. They told us they found it difficult to engage with senior managers in their respective bases to discuss concerns.

- A Staff Partnership Group was in place and had six meetings a year. The constitution outlined that 50% of executive directors would attend each meeting. The staff side members told us they didn't feel attendance was always very good and sometimes the directors left after presenting their paper. They did state it had been improving lately and the Chief executive had started to attend along with the Chief Nurse and Medical Director. We reviewed the minutes of the Staff Partnership Forum for April, May and June 2016. The minutes showed that there were the required numbers of executives present as per the constitution, however, the minutes did not indicate if anyone left or not after they had presented their section.
- The staff side partners echoed many of the perceived concerns that staff told us about. However, following the inspection they contacted us to tell us they did not think there was a culture of bullying in the organisation.
- Staff side partners raised concerns with us about how long it took to deal with grievances and felt that some of the HR advisors were not giving good advice or dealing with things in a timely way. We noted there had been some concerns about the HR department in the organisations development report to the board.
- The trust had recently appointed a new HR Director. The post holder had only been at the trust about two weeks when we carried out this inspection so it was too early to assess any impact from this appointment.
- The NHS Staff Survey asks respondents questions relating to bullying and harassment. Data from the 2016 staff survey showed the number of staff who experienced no harassment, bullying or abuse from managers was the same as the comparator group and an improvement of 2% on the 2015 survey.
- The number of staff experiencing personal discrimination at work from their manager or other colleagues had increased by 2% since the 2015 staff survey but was in line with the national comparator.
- We raised themes of perceptions of bullying and intimidation with the executive team. They were surprised and disappointed to hear this feedback and it was not something that resonated with them. The executive team told us they felt staff were able

Summary of findings

to raise concerns and gave examples of staff getting in touch with them to raise issues directly. This also resonated with what many staff told us because some staff did feel able to raise concerns and could contact the Chief Executive directly.

- Despite the comments we received during the inspection and the staff survey scores on harassment and bullying, the trust had only received four concerns through their internal bullying and harassment or voicing concerns policy.
- In May 2016, the workforce and OD assurance committee sought assurance on the recruitment process to appoint to the Freedom to Speak Up Guardian (FTSU). It was confirmed that a paper in this regard would be presented at ET for discussion. There was no evidence that this was followed up in the next report to the board in September 2016. However, the trust told us that the Board made the required appointment of a FTSU Guardian in October 2016. This post was taken by the trust Company Secretary. We were told the trust board received a development session on the role of the Guardian. A Non-Executive Director champion has also been identified although it is not the intention that they will be the Guardian, but provided an additional route person for staff to speak to if they wanted to raise a concern.
- The trusts sickness levels between April 2016 and June 2016 showed a slight month on month decrease. Between April 2016 and June 2016 the average sickness rate for acute NHS trusts in England was 3.77%, the trusts overall sickness rate in June 2016 was higher at 4.65%.
- The board meeting in May 2016 noted a significant amount of sickness was related to anxiety, stress and depression and asked that the Workforce and Organisational Development Assurance Committee look at this in more detail. In October the OD report to the Trust Board cited some initiatives which were being implemented to help manage the sickness related to anxiety stress and depression, including a Counselling Course, Mental health First Aid training will commence in September 2016 and Mindfulness for Wellbeing.

Fit and Proper Persons

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. The regulation intends to make sure senior directors are of good character and have the right qualifications and experience. Overall we found the trust did not have systems in place to ensure this regulation was met.
- The trust confirmed there was no policy in place to ensure this regulation was consistently applied and adhered to. The

Summary of findings

recruitment procedure was due for review in December 2014 and because it hadn't been updated there was no reference to the FPPR process. The trust had a checklist which they used in the directors files to confirm the FPPR was being followed.

- We looked at the files of four directors. We found the checks made were inconsistent so assurances that directors were fit and proper persons were not in place.
- Not all directors had enhanced disclosed and barring service (DBS) checks in place. The trust had made a decision that where directors were not clinical directors this was sufficient. There was no policy as to when checks were considered necessary and no assessment of risk in place to support why checks had not been completed. Of the four files we looked at, one was in place, one was requested, one was missing and one had been accepted from a previous organisation but this was three years old.
- We discussed the role of non-executive directors as no DBS checks were undertaken on this group of directors. Whilst they were usually accompanied on visits to patient areas we were not assured that staff would not routinely know this and as such may be unlikely to challenge the scope or remit of the visit. This meant non-executives had the authority to visit patient areas but systems to ensure they were not supervised with vulnerable patients were not in place.
- No checks had been completed by the trust to establish if directors had been disqualified as being directors, or if they had been declared insolvent, however, the files did contain a self declaration.
- In two out of the four files references had been obtained, the remaining two files did not have references available.
- We did not see evidence that the trust considered informal sources of information about directors in files but were told that this was completed.
- There were no checks made within directors files of 'Right to work' checks to ensure directors were able to work in the United Kingdom.
- Annual self-declarations of director's personal interests were on file.

Public engagement

- The trusts Patient Experience Strategy was in need of review. A revised strategy was being developed. The trust told us the Strategy had been published in September 2016 on the trusts intranet. We were unable to find evidence of the Strategy on the trusts website.

Summary of findings

- The trust board heard a patient story at the trust board meetings and patient experience was placed at the start of the agenda which is considered good practice.
- The Friends and Family test scores were lower average when compared with other trusts. This test is based on a question asked of patients in all NHS trusts in England, “How likely are you to recommend this ward/clinic to friends and family if they needed similar care or treatment.” During October the Trust received 11,006 FFT ratings and 9,466 comments; response rates overall were good and within national averages; however the Trust was within the 10% of lowest performing Trusts in terms of percentage of patients who would recommend the ward/clinic.
- The Adult Inpatient Survey 2015 received responses from 607 patients. The survey asks questions under 11 areas. The trust was rated about the same as other trusts for all 11 areas, however, the questions relating to patients being **asked to give their views** about the quality of their care and being given enough **information** on their condition or treatment scored worse when compared with other trusts.
- The trust had a small patient engagement team. There were pockets of patient engagement occurring throughout the trust but there was a recognition that they were not all captured. For example, the oncology unit at Lincoln County Hospital had held an open day and there was representation from a patient representative at colorectal department meetings.
- Some work had been completed to improve services through engagement with local groups such as the Lincolnshire Hearing Partnership. An example of this was self-checking kiosks had been introduced to enable patients to self-check for potential sensory impairment.
- Patients were also engaged in capital projects. For example, patient feedback has been collated for the redesign of a new eye department.
- Each hospital had a patient forum which was led by a non-executive director. Patient representatives attended the forums. In addition to this the trust worked with the local Healthwatch and attended their patient forums.
- The trust had volunteers who supported the hospitals in various ways but the trust had recognised the need for further development. The trust were in the process of developing a volunteer’s strategy.
- Due to the lack of medical staff in the emergency departments (ED) at Pilgrim and Lincoln hospital the trust had made a decision to close the ED at Grantham overnight for a proposed period of three months. This happened in August 2016. At the

Summary of findings

time of the inspection there were ongoing concerns being raised by the public about the overnight closure however the trust did not have enough medical staff to be able to provide a safe service in Grantham.

Staff engagement

- The trusts overall engagement score in the 2016 NHS staff survey was 3.75 which was an increase on the 2015 score of 3.68. The score is lower than the national comparator but the increase does suggest efforts to engage staff had made some impact.
- There had been a 3% rise in the 2016 survey for staff who said they would recommend the trust as a place to work. However, this still left the trust 6% short of the comparator for trusts across England.
- There had been a 5% rise in the number of staff who would recommend the trust as a place to receive care in the 2016 NHS staff survey, however, this still left the trust 11% short of the comparator when compared with other trusts in England.
- Medical staff had concerns about pace of improvement and change and felt there was poor engagement between senior medicals leaders and the medical workforce. Many doctors felt morale was low and the trust needed to do more to engage with the medical workforce in order to retain them. The trust had plans in place to improve medical staff engagement. They had a medical engagement plan in place and had developed a clinical management board made up of the 15 clinical directors.
- There was a feeling amongst some of the staff we spoke with that they were overworked, under resourced and undervalued. The trust had attempted to make staff feel more valued and had introduced a staff awards process.
- The trust carried out pulse check surveys on a regular basis. This was an internal survey to assess the level of staff engagement and was used to supplement the national staff survey scores by helping to demonstrate quarter by quarter progress against key parameters compared with a baseline pulse check. Whilst in isolation these may not be statistically significant, they act as more timely signposts of direction of travel. The Workforce and OD Assurance Committee report dated September 2016 outlined between September 2015 to March 2016 the trust received over 1400 staff views; but this was less than the statistically significant recommended response rate. The report notes a statistically significant decrease at Pilgrim Hospital during the quarter January-March 2016 in

Summary of findings

relation to the level of support from line managers and immediate managers acting fairly. The report also acknowledged the workforce was “becoming increasingly tired and at risk of burnout.”

- The Staff Friends and Family Test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. Sixty one percent of staff would recommend the trust as a place to work and 71% would recommend the trust as a place to receive care. The trusts score was worse than average, but was improving and was better than the 2014 score.
- The overall trust NHS Staff Survey for 2015 results showed that four findings were positive, 16 findings were within expected levels and 14 findings were negative. The percentage of staff who experienced harassment, bullying or abuse from patients, relatives or the public had significantly improved since the 2014 survey and was better than the England average (61% in 2014, 42% in 2015, England average 56%).
- The chief executive sent a weekly email blog to all staff. This included things such as vacancies, what was happening in the trust, information about national visits, award winning staff and health information such as the flu vaccine.
- The trust were using social media to keep in touch with staff. The use of closed social media groups were allowing key messages and discussions to take place.

Equality and diversity

- As part of our inspection we reviewed how well the trust was adopting the Workforce Race Equality Standard (WRES) and realistically working towards achieving workforce race equality. The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS community providers. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.
- The trust had been slow to implement the requirements of the WRES and the EDS2 but had recruited an Equality and Diversity lead in September 2016.
- The trust’s WRES report for August 2016 was published on their website and showed 11% of their workforce for the period 2013-2014 were from a visibly black and minority (BME) community background. This percentage of BME staff employed by the trust was higher than that of BME people who lived in the geographical area covered by the trust.

Summary of findings

- The trust had produced an initial report on its position in response to the Work Race and Equality Standards (WRES). Six key themes had been identified for taking the strategy forward. This was at an early stage and staff had not yet been engaged in the strategy.
- The WRES report highlighted there was no black or minority ethnic (BME) group representation at board level. It was highlighted that BME staff were twice more likely to be disciplined than other staff groups. BME staff also reported higher levels of bullying and harassment from staff, this was a significant increase from the 2015 report. The ED lead did not routinely receive a report on levels of bullying and harassment.
- An equality committee chaired by the chief executive had recently been established.
- The trust was planning to host a multi-agency WRES event in October 2016.
- There is a requirement for NHS Trusts to undertake Quality Impact Assessments (EIA) on any service change or change to service provision. We saw evidence the Trust carried out EIA's for policies. We saw evidence of a EIA for a significant service change at Grantham Hospital which commenced in August 2016. This document was labelled as draft and had not been signed off by a lead director.
- The trust had published their Equality Objectives for 2016-17. These objectives were put into an action plan which was approved in August 2016. There were five objectives but progress for implementation was not clear with three actions stating the progress was "Initial plans will be discussed and developed with the Equality, Diversity and Inclusion Committee." There was no clear indication of how this would be delivered, by when and by whom.

Innovation, improvement and sustainability

- The trust had a long history of financial difficulties and was forecasting a year to date £29.7 million deficit in October 2016, compared to plan of £28.7m and was forecasting to achieve its financial plan.
- There was an Deputy Chief Executive in place who was sighted on risk and quality. In October 2016, the trusts financial improvement plan had delivered £9.2 million in financial efficiencies against a target of £8.7million. We were told all cost improvement plans which required a quality impact assessment were now reviewed by either the nurse or medical director. Whilst we did not find evidence of this, there were some concerns expressed by senior staff that the financial

Summary of findings

pressures placed on the organisation had the potential to affect the quality of care being delivered. We were told that up until now nurse staffing had been protected from cost improvement plans, however this was not guaranteed in the coming months.

- The trusts deficit was one of the highest in England and as their costs rose their productivity reduced. This meant there were significant challenges for the trust to rebalance the business and finance aspect of providing acute care alongside quality and safety.
- In 2015/16 the trust spent £30million on agency staff. They were working to reduce this and although they had reduced it by 25% they failed to meet the target set by NHS Improvement. The challenges were mainly driven by the difficulties in recruiting staff. There had been difficulties recruiting overseas staff and there were significant locum costs as a result of shortages of medical staff.
- The chairman had introduced an innovation project which was shared at the end of each board meeting. He had made links with local business, for example, Siemens to help the trust develop and innovate and learn from commercial industry.
- The trust had partnered with NHS England and Coventry University to explore and better understand the relationships between staff experience and patient experience. The Trust had been selected as one of the organisations to implement the Frontier Framework which looks at the possibility that improvements in productivity can sometimes be made at the expense of patient and staff welfare. The framework states that organisations on the frontier are those that are the most efficient. The aim is to drive improvements and experiences for patients by improving staff experience and workforce productivity to replicate and share good practice.

Overview of ratings

Our ratings for Lincoln County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Inadequate	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Grantham Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good

Overview of ratings

Our ratings for Pilgrim Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Inadequate	Requires improvement	Inadequate	Inadequate
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Our ratings for United Lincolnshire Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Outstanding practice and areas for improvement

Outstanding practice

Lincoln County Hospital

- The department inputted hourly data into an emergency department (ED) specific risk tool which had been created, to give an internal escalation level within ED separate to the site operational escalation level. This tool gave an “at a glance” look at the number of patients in ED, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building and there were local actions for easing pressure.
- The department had designed and were using a discharge tool ‘TRACKS’ (T-transport, R-relatives/residential home, A-attire, C-cannula, K-keys, S-safe) to facilitate the safe discharge of older and/or vulnerable patients.
- The trust had introduced a carer’s badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carers badge encouraged carer involvement, particularly for patients with additional needs. Being signed up to the carers badge also gave carers free parking whilst they were in attendance at the hospital.
- Ashby Ward had just introduced visits from pets called a therapy (PAT) dog. PAT is a charity and volunteers from PAT, along with their own pets, visit care organisations to enable patients to interact with them.
- On the care of the elderly wards a red, amber, green system was used to identify patients who required more assistance than others. Red signified those patients who required the most help, whilst green identified those patients who required the least. This system was also applied to each patient’s menu card to signify the amount of support a patient required with eating. Patients with a green sticker were given their meals first. Staff who took meals to patients with a red sticker then stayed to support the patient to eat their meal.
- Staff on Nocton Ward had introduced sibling activity bags for any siblings of the infants admitted on the ward. This demonstrated a positive approach to involving the whole of the family in the service experience.

Areas for improvement

Action the trust MUST take to improve

Lincoln County Hospital

- The trust must take action to ensure staff in the emergency department are appropriately trained and supported to provide the care and support needed by patients at risk of self-harm.
- The trust must take action to ensure all staff working in the emergency department receive appropriate supervision, appraisal and training to enable them to fulfil the requirements of their role.
- The trust must take action to ensure systems and processes are effective in identifying where safety is being compromised and in responding appropriately and without delay. Specifically, systems and processes to identify and respond to the assessment and treatment of sepsis in the emergency department.
- The trust must take action to ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department.
- The trust must continue to ensure systems and processes are effective and that staff respond appropriately in recognising and treating patients in line with the trust’s sepsis six care bundle.
- The trust must take action to ensure ligature risk assessments are undertaken and that ligature cutters are available in all required areas.

Outstanding practice and areas for improvement

- The trust must take action to ensure staff in maternity are appropriately trained and supported to provide recovery care for patient's post operatively.
 - The trust must take action to ensure all staff working in the termination of pregnancy service receive formal counselling training.
 - The trust must take action to ensure that the handover process on Nettleham ward does not compromise patient's privacy.
 - The trust must take action to ensure that sensitive patient groups are not mixed within gynaecology and maternity outpatient areas.
 - The trust must ensure the environment within clinic 6 is reviewed and actions taken to prevent or control the potential risk to patients from infections. The trust must comply with the Health and Social Care Act 2008, Code of Practice On the prevention and control of infections and related guidance.
 - The trust must ensure that the drinking water dispensers are cleaned and maintained in accordance the manufacturer's instructions including completion of scheduled electrical safety testing, a water hygiene maintenance programme and cleaning schedule.
 - The trust must ensure that equipment is appropriately maintained. Ensure any checks carried out by staff are recorded and done with sufficient frequency and with sufficient knowledge to minimise the risk of potential harm to patients.
 - The trust must ensure that patients who are referred to the trust have their referrals reviewed in a timely manner to assess the degree of urgency of the referral.
 - The trust must ensure that the patients who require follow up appointments are placed on the waiting list.
- Pilgrim Hospital
- The trust must ensure systems and processes are effective in identifying and treating those patients at risk of sepsis.
 - The trust must ensure that there are processes in place to ensure that patients whose condition deteriorates are escalated appropriately.
 - The trust must take action to ensure safety systems, processes and standard operating procedures are in place to ensure there is an on-call gastrointestinal bleed rota to protect patients from preventable harm.
- The trust must ensure that all staff have an appraisal and are up to date with mandatory training, and ensure staff in the emergency department have received appropriate safeguarding training.
 - The trust must ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department.
 - The trust must ensure there is an adequate standard of cleaning in the emergency department.
 - The trust must ensure staff comply with hand decontamination in the emergency department.
 - The trust must ensure that patient records in the emergency department are complete; specifically that risk assessments, pain scores and peripheral cannula care are documented.
 - The trust must ensure patient records are kept securely in the ambulatory emergency care unit (AEC).
 - The trust must ensure governance and risk management arrangements are robust and are suitable to protect patients from harm.
 - The trust must take action to ensure there is a robust process in place to report incidents appropriately and investigate incidents in a timely manner and staff receive feedback, lessons are learnt and shared learning occurs.
 - The trust must take action to ensure safety systems, processes and standard operating procedures are in place to ensure there is an on-call gastrointestinal bleed rota to protect patients from preventable harm.
 - The trust must take action to ensure systems and processes are effective staff respond appropriately in administering treatment in the recommended time frame in accordance to the sepsis six bundle of care.
 - The trust must take action to ensure systems, processes are in place to reduce the significant number of omitted medication doses, and any omissions recorded in accordance with trust policy.
 - The trust must take action to ensure ligature risk assessments are undertaken in all required areas.
 - The trust must take action to ensure ligature cutters are accessible and available when needed to meet the needs of people using the service.
 - The trust must take action to ensure there are sufficient numbers of suitably qualified competent, skilled and experienced staff to meet the identified needs of patients.

Outstanding practice and areas for improvement

- The trust must take action to ensure the Care Quality Commission (CQC) is informed about any DoLS applications made in line with Regulation 18 of the Health and Social Care Act 2008 (Registrations) Regulations 2014.
 - Include evidence of outcomes and learning from complaints within communication with staff.
 - The trust must take action to ensure that people are told when something goes wrong.
 - The trust must take action to ensure that emergency equipment in the antenatal day unit is checked when the unit is in use.
 - The trust must take actions to ensure that staff within gynaecology have greater involvement in the reporting and monitoring of incidents. This would include sharing learning from historical incidents.
 - The trust must take action to ensure staff in maternity are appropriately trained and supported to provide recovery care for patients post operatively.
 - The trust must take action to ensure that all staff receive basic life support and infection prevention and control training.
 - The trust must take action to ensure all staff working in the termination of pregnancy service receive formal counselling training.
 - The trust must take actions to ensure that all paperwork is correctly completed to ensure Human Tissue Authority guidance is followed in the disposal of fetal remains.
 - The trust must take actions to ensure that when gynaecology patients are admitted the inpatient records are found as soon as possible. Where temporary patient notes are created, these must be combined with inpatient records as quickly as possible.
 - The trust must take actions to ensure that the area designated as the labour ward recovery area is ready for use with privacy maintained at all times.
 - The trust must complete a ligature risk assessment of the Children's ward where CAMHS patients are admitted.
 - The trust must ensure paediatric medical staffing is compliant with the Royal College of Paediatrics and Child Health (RCPCH) standards.
 - The trust must ensure nurse staffing on the children's ward is in accordance with Royal College of Nursing (RCN) (2013) staffing guidance.
 - The trust must ensure there is at least one nurse per shift in all clinical areas trained in either advanced paediatric life support (APLS) or European paediatric life support (EPLS) as identified in the RCN (2013) staffing guidance.
 - The trust must ensure staff adhere to the trust's screening guidelines for screening for sepsis.
 - The trust must ensure the management of health records enables the safe care and treatment of patients, compliance with information governance requirements and ensures patient confidentiality is maintained. This includes the availability, the condition and storage of medical records.
 - The trust must ensure that equipment is appropriately maintained. Ensure any checks carried out by staff are recorded and done with sufficient frequency and with sufficient knowledge to minimise the risk of potential harm to patients.
 - The trust must ensure that patients who are referred to the trust have their referrals reviewed in a timely manner to assess the degree of urgency of the referral.
 - The trust must ensure that the patients who require follow up appointments do not suffer unnecessary delays and are placed on the waiting list.
 - The trust must ensure patients have complete and recorded outcomes to ensure there are documented decisions and actions in relation to their treatment and care.
- Grantham Hospital
- The trust must take action to ensure that the environment in the emergency department is fit for purpose
 - The trust must take action to ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department.
 - The trust must ensure there are sufficient numbers of medical and nursing staff working in the emergency department who have up to date and appropriate adult and children resuscitation qualifications.
- Provider wide
- The trust must take action to ensure they are compliant with the Fit and Proper Person requirement.
 - The trust must ensure they are compliant with the requirements of the Duty of Candour.

Outstanding practice and areas for improvement

- The trust must ensure there is good governance within the organisation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors</p> <p>Regulation 5 (3) (a)</p> <p>The individual is of good character,</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">· There was no policy and procedure in place to ensure the fit and proper person requirement was consistently met.· We reviewed the files of four directors. There were significant gaps found for required checks.· There no checks in place directors had not been declared insolvent or disqualified from holding directorships.· One director was confirmed in post without any FPPR checks being in place or commenced.· Directors did not always have Disclosure and Barring Service (DBS) check in place or some had been accepted that were completed by other organisations. These were not recent.
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 20 HSCA (RA) Regulations 2014 Duty of candour</p> <p>Regulation 20 1,2,3,4,5</p> <p>Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.</p> <p>How the regulation was not being met:</p>

This section is primarily information for the provider

Requirement notices

The provider was not assured there were adequate systems and processes in place to meet the requirements of the duty of candour regulation.

Regulated activity

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 1 (a, b, c, d, e, f)

Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

How the regulation is not being met:

- There were weaknesses in the trusts governance framework to support the delivery of the trusts vision, strategy and good quality care.
- We were not assured the board were sufficiently sighted on risk.