United Lincolnshire Hospitals NHS Trust

Pilgrim Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Inadequate
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Inadequate
Surgery	Good
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focused inspection to United Lincolshire Hospitals NHS Trust so we could follow up on improvements that had been made since our last inspection. This was our third inspection to the trust since the introduction of our new inspection methodology. The announced inspection took place between the 10-14, 18-19 and 26-27 October 2016. We also carried out unannounced inspections to Pilgrim Hospital on 24, 25 and 27 October 2016. We carried out a further unannounced inspection on 19 December 2016 in respone to information we had received from members of the public/relatives of patients.

Overall, we rated Pilgrim Hospital as inadequate. The medical service and the outpatients and diagnostic imaging service were rated as inadequate, urgent and emergency services and maternity and gynaecology services were rated as requires improvement and surgery, critical care and services for children and young people were rated as good.

Our key findings were:

Safe

- The approach to reviewing and investigating incidents in some services was insufficient and too slow and led to unacceptable delays. However, there was a positive approach to reporting and learning from incidents in the critical care unit.
- We were not always assured incidents were reported appropriately, investigated, that lessons were learnt and shared in a timely way. However, some staff told us they had received feedback following raised incidents and could give examples of where learning from incidents had taken place.
- Where patients had met the criteria for treatment of sepsis, staff were not always responding appropriately in administering treatment in the recommended time frame and in line with the “sepsis six” care bundle.
- We were not assured patients were receiving their medication as prescribed.
- Individual care records were not always written and managed in a way that kept people safe. Some records were incomplete and not up-dated to reflect patients care needs.
- Fluid balance charts in some areas were not always updated appropriately to minimise risks to patients.
- Staff training compliance for safeguarding adults and children did not meet the trusts mandatory target of 95% completion. We were therefore not assured all staff would be able to respond appropriately.
- Not all areas met the trust target of 95% for a majority of their mandatory training and compliance was variable across the hospital.
- Nurse and medical staffing levels and skill mix were not always appropriate to keep patients protected from avoidable harm at all times. However, there were the appropriate numbers of staff on duty in the critical care unit.
- The hospital participated in the national safety thermometer scheme but it was not always displayed in the ward areas.
- The poor condition of and unavailability of health records was having a negative impact on all clinic areas, resulting in appointment delays, additional anxieties and work for clinic staff and causing difficulties and delays in medical information being located.
- The hospital did not secure records in a way, which protected patient confidentiality. We saw numerous occasions where staff left confidential records in public areas. The environment was hazardous for administrative staff in areas where boxes of medical records had been inappropriately stored.

Summary of findings

- Data from the trust showed 18,636 patients had been missing on the electronic patient administration system. Of these, 1,119 patients required a further appointment meaning they had been missing from the waiting list. There was an ongoing process to continue to identify further patients missing from waiting lists. This presented a risk to patients' ongoing treatment and care.

Effective

- The trust's 'rolling 12 month' Hospital Standardised Mortality Ratio (HSMR) for April 2015 to March 2016 was 101.5.
- The latest published Summary Hospital-level Mortality Indicator (SHMI) for July 2015 to June 2016 was 1.101 which was as expected.
- Outcomes for patients were sometimes below expectations when compared with similar services at a national level.
- Generally, care and treatment was planned and delivered in line with current evidence based guidance but there were times when care and treatment didn't followed evidence based guidance.
- Patient outcomes were variable compared to similar services and some standards were not measured or audited.
- Not all staff had the right qualifications, skills, knowledge and experience to do their job. Not all staff had the training or completed competences recommended by the trust to care for patients with a tracheostomy or to care for patients receiving non-invasive ventilation.
- There was no policy for restraining patients but we found evidence that patients had received tranquilisation drugs in order to sedate them.
- Generally there was good multidisciplinary working across the service. This included support from community staff who attended meetings to discuss patient care.
- There was a colour coded system to signify assistance required for patients to maintain dietary and fluid requirements.
- Endoscopy services at this hospital were Joint Advisory Group (JAG) accredited.
- A dementia care practitioner was available to support patients living with dementia.
- The maternity service used a maternity dashboard but they did not use this to set local goals for each of the parameters monitored, as well as upper and lower thresholds

Caring

- Generally patients and relatives spoke positively about the care they received. Staff treated patients with kindness and compassion and provided emotional support. Staff were friendly and professional in their interactions with patients and relatives and patients felt involved in their care and informed about the care they received.
- However, we observed some instances within the medical service of the hospital where patients were not treated with compassion, dignity and respect. We also received concerns from members of the public/relatives about the care being delivered.
- We observed some instances where patients basic care needs were not always met.

Responsive

- Some patients were not able to access services for assessment, diagnosis or treatment when they needed to.
- 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 had failed to meet the majority of the national standards for the cancer referral to treatment targets. This included the referral standard for patients suspected of cancer who needed to be seen with two weeks. This standard had not been consistently met during 2016.
- 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. These did not include the patients identified as missing from the waiting lists.

Summary of findings

- There was insufficient consideration paid to meeting the information and communication needs of patients. The service had not taken steps to meet the requirements of the accessible information standard. However, staff could access interpreting services for patients who did not speak or understand English.
- Maternal choice for a midwife led unit delivery was limited and there were no designated bereavement areas for families who had lost a baby.

Well led

- Not all staff were aware of the vision and strategy for the trust and some staff felt uncertain about the future of the hospital.
- There was not always an effective governance framework which supported the delivery of safe, good quality care.
- Risks were not always dealt with appropriately or in a timely way.
- We received mixed feedback from staff about morale and feeling they could raise concerns and were listened to. Some staff reported morale as good in their clinical area, where as others were less engaged with the hospital and did not feel as comfortable to raise concerns.
- We were not assured that all of the local leaders had the necessary knowledge and capability to lead effectively because in some areas they were out of touch with the clinical care being delivered on the front line. In some areas, there was a lack of clarity about how staff were held to account.

We saw several areas of outstanding practice including:

- The emergency department was trialling the introduction of a hot meal for those patients who were able to eat at lunchtime.
- 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 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.
- 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.

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

Importantly, the trust must:

- 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.

Summary of findings

- 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 avoidable 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 avoidable 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 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.
- 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 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.

Summary of findings

- 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.

In addition the trust should:

- The trust should ensure there are robust systems in place to ensure all incidents are reported, investigations occur in a timely manner, staff receive feedback and processes are in place to ensure learning occurs.
- The trust should ensure that governance procedures are robust, risks are clearly identified and that there is a comprehensive assurance system.
- The trust should ensure ligature cutters are immediately available in the ED.
- The trust should ensure that the resuscitation trolleys and their equipment are checked, properly maintained and fit for purpose in the emergency department.
- The trust should implement the difficult airway trolley in the emergency department at the earliest opportunity.
- The trust should ensure the proper and safe management of medicines, including storage at the correct temperature in the emergency department.
- The trust should ensure it continues to work to response to the increased capacity and improve flow through the emergency department in order to ensure patients are seen by a registered healthcare practitioner in 15 minutes, do not have to wait longer than four hours and that ambulance handovers happen within 15 minutes.
- The trust should ensure there is 16 hours of consultant presence each day.
- The trust should ensure there is a suitable room in ED to treat those patient with mental health needs.
- The trust should consider if mental capacity assessments and best interest decisions for patients attending the emergency department are recorded in line with the Mental Capacity Act.
- The trust should ensure staff are appropriately trained and supported to meet the requirements related to duty of candour.
- The trust should ensure an annual audit is carried out in line with the recommendations of The Royal College of Emergency Medicine (RCEM) guidelines; Management of Pain in Children (revised July 2013).
- The trust should consider how the emergency department can comply with the accessible standard for information and also how facilities for the hard of hearing can be improved at the reception area of the emergency department.
- The trust should consider how the environment in the emergency department could be more dementia friendly.
- The trust should ensure mandatory training is completed in line with trust policy.
- The trust should ensure safeguarding adults and children's training is completed in line with trust policy.
- The trust should ensure standards of hygiene and cleanliness at all times to prevent and protect people from healthcare-associated infection.

Summary of findings

- The trust should ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.
- The trust should ensure observation charts for monitoring fluid balance of patients are completed to ensure the health, safety and welfare of the service users.
- The trust should ensure systems, processes, standard operating procedures are in place to ensure documentation, and checklists for the safe delivery of care for patients with a tracheostomy are completed and displayed in accordance with trust policy.
- The trust should ensure evidence based guidance is followed. The trust did not follow national guidance for the administration of rapid tranquilisation medication.
- The trust should ensure staff training on Consent, Mental Capacity Act and Deprivation of Liberty Safeguards is completed in line with trust policy.
- The trust should ensure staff appraisal rates are completed in line with trust policy.
- The trust should ensure patient records are kept securely.
- The trust should ensure all fridge temperatures for the storage of medication are recorded in line with trust policy.
- The trust should ensure staff training on Consent, Mental Capacity Act and Deprivation of Liberty Safeguards is completed in line with the trust target of 95%.
- The trust should ensure do not attempt cardio pulmonary resuscitation (DNACPR) orders are completed and mental capacity assessment for those deemed to lack capacity are completed in line with trust policy and national guidance.
- The trust must ensure pain assessments tool are completed for patients in line with evidence based guidance and staff are clear about the specialist pain team referral pathway.
- The trust should ensure systems are robust to identify vulnerable patient groups including, but not exclusive to, patients living with dementia and patients with learning disabilities.
- The trust should ensure there are robust systems in place to manage quality and safety issues in the absence of the Quality and Safety Officer (QSO) for the medicine directorate.
- The trust should ensure patient records are kept securely.
- The trust should ensure all fridge temperatures for the storage of medication are recorded in line with trust policy.
- The trust should ensure that staff vacancies are recruited into to meet the patient acuity within this service.
- The trust should ensure that the emergency call bells on the risk register since 2014 are installed.
- The trust should ensure they review the consultant rota to ensure that the rota is sustainable, and that consultants receive 11 hours rest in line with the European working time directive.
- The trust should ensure there is an allocated physiotherapist to surgical ward areas.
- The trust should ensure that a Psychologist or Counsellor are available to support vascular amputation patients.
- The trust should ensure that the measures are addressed for the National Emergency Laparotomy Audit.
- The trust should ensure that the safety thermometer is displayed in all areas.
- The trust should ensure that all staff receive a yearly appraisal.
- The trust should ensure they address concerns regarding the clinical waste arrangements with disposal trolley bins permanently outside the theatre corridor.
- The critical care unit should display safety thermometer outcomes within the department so that staff and visitors are informed of safety outcomes for the unit.
- The critical care unit should establish a recorded program of equipment maintenance and capital replacement in line with standards for equipment in critical care.
- Critical care should consider improving links with speech and language therapists to ensure patients are able to swallow effectively following tracheostomy or long term intubation.
- The critical care department should consider increasing the number of staff able to access the post registration award in critical care nursing.
- The senior management team should consider incorporating CCOT into the critical care team to facilitate continuity of care between critical care and the wards.

Summary of findings

- Critical care should consider integrating a named medical consultant when caring for emergency medical patients, to ensure continual and consistent treatment for these patients on discharge from the unit.
- Critical care should review the service in line with intensive care standards.
- Critical care should consider collecting data to reflect their delayed discharges by speciality and reason to support this topic on the risk register.
- The trust should take actions to ensure that NICE guidance is followed in the provision of care for patients with hypertensive disorders in pregnancy.
- The trust should ensure that the new IT system supports accurate documentation of safety thermometer data.
- The trust should ensure that notes for patients undergoing caesarean section are consistent including standardised documents.
- The trust should ensure that safeguarding supervision is provided regularly for all staff.
- The trust should ensure that if recent NICE guidance is not followed then the current guidance includes an addendum to explain the current decision. (CG 190)
- The trust should audit the length of time patients attending for emergency gynaecology appointments are expected to wait.
- The trust should take action to improve the provision of multidisciplinary training.
- The trust should ensure that within maternity service users feedback is captured.
- The trust should ensure that action plans are made following audits, and a reaudit is performed, such as following the regular CTG audits.
- The trust should consider delivering more transition clinics for other long-term conditions other than diabetes and cystic fibrosis.
- The trust should ensure they devise an abduction policy for the neonatal unit and children's ward, and test the policy regularly.
- The trust should ensure all staff follow best practice documentation guidance to ensure all entries into clinical notes is of a satisfactory level and in line with professional standards.
- The trust should ensure staff working in the children and young people's service receive formal clinical supervision.
- The trust should ensure outpatient and diagnostic services are delivered in line with national targets.
- The trust should ensure staff report incidents in line with trust policy.
- The trust should ensure staff are reminded of the procedures regarding fridge temperatures falling outside expected range.
- The trust should take action to ensure all staff working in the outpatient and diagnostic services receive an annual appraisal to ensure they are able to fulfil the requirements of their role.
- The trust should consider whether the action taken to reduce the back log of clinic letters waiting to be sent to GPs and patients following their appointment was effectively resolving the backlog of letters.
- The trust should ensure all staff are supported and are not subject to any behaviour falling outside the trust code of conduct.
- The trust should ensure all staff know their responsibilities and expectations regarding screen breaks.
- The trust should continue to review the progress and effectiveness of the outpatient transformation programme and work undertaken to reduce diagnostic backlogs.
- The trust should ensure staff documented ultrasound probe cleaning.

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

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated urgent and emergency services as requires improvement overall. We rated safe as inadequate, effective, responsive and well led as requires improvement and caring as good. Systems, processes were not always reliable or appropriate to protect patients from avoidable harm. Staff did not consistently follow guidance to ensure patients were screened for sepsis or received sepsis treatment in a timely manner. Not all patients were seen in 15 minutes by a registered healthcare professional. Staff did not consistently complete risk assessments for patients.There was no on call gastrointestinal bleeding (GI) rota to provide treatment anytime of the day or night. Whilst there was an incident reporting process in place, we were not assured that all incidents were reported, incidents were investigated in a timely manner or lessons were learnt and shared with all members of staff. Not all areas were visibly clean and cleaning audits achieved less than trust targets. Not all staff decontaminated their hands and staff did not routinely submit hand hygiene audits. The trust were addressing hand hygiene audit submissions. The size of the department meant patients were sometimes cared for in the central area as not enough cubicles were available. No risk assessment of the environment to identify ligature points and minimise risks to patients had been undertaken. There were no ligature cutters or difficult airway trolley available. Emergency equipment was not checked in line with trust policy. There was no pharmacy support for staff and we found out of date medicines. Medicines fridge temperatures were not checked in line with trust policy and the medicine fridge in the emergency department (ED) was not working correctly. In ambulatory care unit (AEC) records were not stored securely and there were delays in returning records to the medical records department.

Summary of findings

Consultant presence in the ED was less than the recommended 16 hours a day. Medical and nursing staffing was reliant on locum, agency and bank staff. However, the trust was actively addressing this.

Staff did not consistently follow some guidelines, for example, sepsis screening and care. Staff did not consistently document patient pain assessments. Processes were not in place to ensure that all staff received appraisals. Safeguarding and mandatory training was below trust targets. The trust were unable to provide assurance that registered nurses had undertaken specific competencies in order to care for children.

The NHS Friends and Family Test (FFT) results were slightly worse than the England average and patient privacy was compromised at times in the second triage room.

Governance, risk management and quality measurement processes were not robust. Governance meetings were in their infancy. There were no robust mechanisms for feeding back results of audit or results of the safety quality dashboard (SQD). Morbidity and mortality meetings were not held consistently. There was inconsistency between the risks that had been identified on the risk register and what staff said the risks were. Staff were not always involved in changes to the provision of services.

Patients and relatives spoke positively about the care they received. Staff treated patients with kindness and compassion and provided emotional support. Staff were friendly and professional in their interactions with patients and relatives and patients felt involved in their care and informed about the care they received.

The service had accessed NHS Interim Management and Support (IMS) in order to review ways of working within the emergency department (ED) and improve the quality and efficiency of patient care.

Staff administered medicines in a timely manner and advance nurse practitioners had undertaken further training to be able to prescribe medicines. Staff ensured patients' nutrition and hydration needs were met, and patients were offered hot meals. Staff had good understanding of consent procedures.

Summary of findings

There was an electronic tool, which calculated the level of risk in ED this was used to monitor and escalate the level of risk. Staff had twice daily safety huddles and were seen to respond quickly and efficiently to emergency situations.
Generally, care and treatment was planned and delivered in line with current evidence based guidance, and the service participated in some national audits.
Staff worked collaboratively with each other and with other teams within the hospital to provide care that was coordinated and appropriate. The culture was friendly and supportive, staff worked as a team and local leaders were visible and approachable.
Staff were aware of the trust's vison and consistently demonstrated the values of the organisation.

Medical care (including older people's care)	**Inadequate**	
Surgery	**Good**	Overall we rated surgical services as good. Staff recognised concerns, incidents or near misses and gave us example of when they may report these. Staff said they received feedback following raised incidents and could give examples of where learning from incidents had taken place. Equipment checked was within its service date and new equipment was evident across the service. Most clinical areas were visibly clean, uncluttered and well organised. We observed staff providing kind and compassionate care to patients and their relatives in all areas we visited. Friends and Family Test data (FFT) showed an average of 86% of patients on surgical wards said that they would recommend the service. Staff within this service showed a commitment to improving services and felt well supported by senior staff. Senior staff were well respected and valued by staff who described them as dedicated and hardworking. However;

Summary of findings

Staff knew how to report incidents and what should be reported but incidents remained open on the system.
The trust results in the National Emergency Laparotomy Audit showed out of 11 measures only two areas were compliant with eight measures amber and one red.
Patient records were stored in unlocked trollies, staff told us that new locked trollies were being delivered to those wards that currently did not have them but had not arrived during this inspection.
There was no formal psychologist or counselling support for vascular patients following amputation.
Medical outliers were admitted to the surgical wards, which resulted in cancelled operations which was outside the control of this service.
Risks were not always dealt with appropriately or in a timely way. For example, the absence of emergency call bells on the surgical wards had been on the risk register since 2014 but minutes at the governance performance meeting in May 2016 showed that the risk remained unresolved.

Critical care

Good

Overall, critical care service was rated good for safe, effective, caring, responsive and well led.
The critical care unit appeared visibly clean and promoted patient safety through established infection control processes, with no reported incidents of meticillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (C.Difficile).
Local audits showed staff consistently used good hand hygiene practices and were bare below the elbow in line with best practice.
There were adequate medical and nursing staff to meet the recommended staff to patient ratio, as defined in the core standards for intensive care units.
The department planned and provided care according to national and local guidelines and was an active member of the Mid Trent critical care network, where common working policies were developed and agreed.
We observed staff providing compassionate care and maintaining patient privacy and dignity at all times.
The unit was responsive to local demand by using beds flexibly according to the level of care required.

Summary of findings

The unit worked collaboratively with the colorectal cancer service to provide facilities and care for the post-operative patients at level one (enhanced ward level care).
Patients were supported on discharge by the critical care outreach team .Those receiving level three (Intensive care) had the opportunity to attend a post critical care clinic for longer-term support.
The service was led by experienced senior manager with the skills and capability to lead the service effectively .Staff told us they felt supported to carry out their roles within the unit.
However the critical care unit informed the inspection team that delayed patient discharges was a problem for the unit and this was on the departments risk register. However, the unit did not keep a comprehensive record of delayed discharges.
The critical care unit did not have the recommend number of nurses with a post registration qualification in critical care nursing as defined in the core standards for intensive care units.

Maternity and gynaecology

Requires improvement

We rated this service overall as requires improvement.
Many of the audits did not provide plans for presentation of findings to colleagues or current timelines.
Staff had not received recovery update training.
The unit struggled to gain feedback from the non-English speaking population.
Maternal choice for a midwife led unit delivery was limited.
There were no designated bereavement areas for families who had lost a baby.
The gynaecology ward often included non-gynaecology patients.
The labour ward recovery area was not set up for use or in a private room.
Data collection was not robust due to discrepancies in collection.
Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons were learned and communicated to staff.
Clinical areas were visibly clean and attempts were made to improve the working environment.

Summary of findings

Safeguarding support for staff had increased with the introduction of specialist midwives.
Women's care and treatment was planned and delivered in line with current evidence based guidance.
Staff gained consent prior to all care and treatment, including for disposal of fetal remains.
Staff received appraisals and were supported in training with practice development staff.
Staff responded compassionately and families were treated with kindness and respect.
Women were aware of how to complain and their complaints were taken seriously.
The women's and children's service was driven by quality. Despite an unknown future short term changes were performed to improve services for women.
Governance structures functioned effectively and interacted appropriately. Teamwork throughout the hospital was apparent and staff felt they were listened to.

Services for children and young people

Good

Overall, we rated this service as good overall but safety required improvement.
Nurse and medical staffing did not meet requirements of the Royal College of Nursing (RCN) and Royal College for Paediatric and Child Health (RCPCH). Nurse staffing on the children's ward did not have an experienced member of staff on for each 24-hour period and did not provide at least one member of staff with advanced paediatric life support (APLS) or European paediatric life support (EPLS) qualification on each shift. There were insufficient members of the medical team to provide paediatric consultant cover seven days per week. In addition, consultant cover provided did not cover the busy 12 hour period up to 10pm.
Despite the implementation of a sepsis management pathway by the trust in 2014, we found this had not been embedded. Children and young people were not screened for sepsis when observations had identified them as at risk of sepsis.
There was a lack of awareness on the children's ward in relation to ligature risks, for example, we did not see a ligature risk assessment had been carried out and there were no ligature cutters

Summary of findings

immediately available in the ward area. There was no abduction policy, therefore were no assured that staff would know what actions to take in the eventuality of a missing child.
We could not be assured that staff followed the did not attend (DNA) policy for the children's outpatient department, and there was no DNA monitoring of paediatric patients in departments where children attended.
Staff demonstrated a good knowledge about incident reporting and evidence of learning from incidents. The numbers of incidents were low compared to other sites within ULHT and there had been no never events or serious events in the last 12 months.
There was evidence of good risk assessments for children and young people admitted to the service at this hospital, this included infection control; bed rails assessment and skin integrity assessments.
There was evidence of reviewing the risk assessments within the appropriate timescales.
Regular pain assessments were undertaken adapted to the age group of the child being assessed.
There were no reported cases of MRSA bacteraemia or Clostridium difficile for the service in the last 12 months.
The service delivered care according to local and national policies which were evidence based. They had received accreditation for the evidence-based care, which was being delivered.
We observed staff providing care, which was compassionate and engaged at a level, which was age appropriate. Children and their parents were involved in their care and told us they were given adequate amounts of information about their care and treatment.
The service was responsive to the needs of those accessing the services. The individual needs of children and young people were being met and staff had attended courses to enable them to communicate with those that had hearing impairments.
The service was well led at local ward/unit level and staff told us and we found the leadership above this level was also good.

Summary of findings

Outpatients and diagnostic imaging

Inadequate

We rated this service as inadequate because:
Outpatient services did not manage and maintain medical records in a way, which enabled the safe care and treatment of patients, complied with information governance requirements, or ensured patient confidentiality. This included the availability, the condition and storage of medical records.
Data showed continuous poor performance against national cancer targets. We saw significant numbers of patients overdue for appointments including new and follow up appointments. In some cases, the 2016 position was worse than the previous year. The trust performance against referral to treatment times had declined between June 2016 and September 2016.
Data showed 8,108 incomplete patient appointment outcomes, which staff did not record on the electronic record system. Data supplied by the trust showed the current position was worse than the previous year.
There had been significant delays in the reporting of diagnostic imaging results due to technical difficulties. This affected patients receiving timely access to care and treatment.
Not all staff reported incidents in line with trust policy. Therefore, not reporting incidents presented a risk to patients because it meant departments could not put mitigating in place to prevent an incident from happening again.
There were delays in staff typing and sending clinic letters to GPs and patients. We saw significant numbers of letters waiting to be typed.
Not all staff received appraisals in a timely manner. Some staff we spoke with said their appraisals were not meaningful and did not provide opportunities to develop. In particular, administrative staff did not benefit from regular or meaningful appraisals.
Progress against some poor performance and identified risks was slow. We saw issues identified since our last inspection had not been address for example, overbooking of clinics. Reports showed there had been long standing issues for example, condition of health records, which the trust had not addressed.
We had concerns in relation to the culture in some outpatient departments. Some staff said they had

Summary of findings

experience bullying and intimidating behaviour particularly from managers. The majority of administrative staff we spoke with said managers did not support or listen to them. There were shortages in administrative staffing.
However we also found:
Staff delivered patient care in line with evidenced based care and best practice guidelines. Staff had access to relevant trust policies and national guidelines to support them deliver patient care.
Staff reported incidents in line with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R
There was effective multidisciplinary working with staff, teams and services working together to deliver care and treatment to meet the patient's needs.
Staff from different specialties and roles provided one-stop clinics in some departments.
Staff were caring, compassionate and involved patients in their care and treatment. We saw positive interactions between staff. Patients were positive about their care and treatment. Staff supported patients in the event of bad news.
Services met the needs of local people with some specialist services available for patients. Some clinics developed new ways of working to meet demand and address overdue appointments for example virtual clinics.
Staff had access to translation and interpretation services and where possible used their resources to enhance the patient's care pathway.
We saw some examples of patient and staff involvement. We saw where changes had occurred because of patient and staff involvement.
We saw examples of departments innovating to improve care for patients.

Pilgrim Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care ; Surgery; Critical care; Maternity and gynaecology; Services for children and young people; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Pilgrim Hospital

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.

Pilgrim Hospital provides A&E, elective surgical procedures, critical care (level 1, 2 and 3) medical care (including care to older people), maternity, services to children and young people, end of life care and outpatient services.

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.

Detailed findings

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

We also carried out unannounced inspections to Pilgrim Hospital on 24, 25 and 27 October 2016 and 19 December 2016.

Facts and data about Pilgrim Hospital

There are 461 beds (inpatient & day case) 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.

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	

Detailed findings

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

Our ratings for this hospital

Our ratings for this hospital are:

	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	Not rated	Good	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Notes

Urgent and emergency services

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

Information about the service

Urgent and emergency services are provided by United Lincolnshire Hospitals NHS Trust at three sites across Lincolnshire: Lincoln County Hospital; Pilgrim Hospital Boston and Grantham and District Hospital. 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.

At Pilgrim hospital, the urgent and emergency services consist of the emergency department (ED) and an Ambulatory Emergency Care (AEC) unit.

The ED provides consultant-led emergency care and treatment 24 hours a day, seven days a week to people across Lincoln and the North Lincolnshire area. The department has a triage room, an advanced triage room, 13 'major' and three 'minor' cubicles, a four-bedded resuscitation area, three cubicles used by the rapid assessment and intervention team (RAIT), an ear nose and throat (ENT) treatment room, a plaster room, two waiting rooms, one for adults and one for children and a quiet/relatives room.

The ambulatory emergency care unit (AEC) is open from 8.30am to 10pm, Monday to Friday and provides care to adults only. The unit has six beds and two seated areas. Patients are referred by their GPs or, if appropriate, transferred from ED. The deep vein thrombosis (DVT) clinic is situated in the AEC unit.

From September 2015 to August 2016, 56,155 patients attended ED; of these 9,300 (17%) were under 16 years or younger.

We visited all areas of ED and the AEC unit. We spoke with 11 patients, eight relatives and 44 staff. These included service leads, senior and junior doctors, senior and junior nurses, health care assistants, administrative and housekeeping staff. We also spoke with four non-trust staff. We observed interactions between patients, relatives and staff. We considered the environment and looked at 21 patient records.

Urgent and emergency services

Summary of findings

We rated urgent and emergency services as requires improvement overall.

We rated safe as inadequate, effective, responsive and well led as requires improvement and caring as good.

- Systems, processes were not always reliable or appropriate to protect patients from avoidable harm. Staff did not consistently follow guidance to ensure patients were screened for sepsis or received sepsis treatment in a timely manner. Not all patients were seen in 15 minutes by a registered healthcare professional. Staff did not consistently complete risk assessments for patients. There was no on call gastrointestinal bleeding (GI) rota to provide treatment anytime of the day or night.
- Whilst there was an incident reporting process in place, we were not assured that all incidents were reported, incidents were investigated in a timely manner or lessons were learnt and shared with all members of staff.
- Not all areas were clean and cleaning audits achieved less than trust targets. Not all staff decontaminated their hands and staff did not routinely submit hand hygiene audits. The trust were addressing hand hygiene audit submissions.
- The size of the department meant patients were sometimes cared for in the central area as not enough cubicles were available. No risk assessment of the environment to identify ligature points and minimise risks to patients had been undertaken.
- There were no ligature cutters or difficult airway trolley available. Emergency equipment was not checked in line with trust policy.
- There was no pharmacy support for staff and we found out of date medicines. Medicines fridge temperatures were not checked in line with trust policy and the medicine fridge in the emergency department (ED) was not working correctly.
- In ambulatory care unit (AEC) records were not stored securely and there were delays in returning records to the medical records department.
- Consultant presence in the ED was less than the recommended 16 hours a day. Medical and nursing staffing was reliant on locum, agency and bank staff. However, the trust was actively addressing this.
- Staff did not consistently follow some guidelines, for example, sepsis screening and care. Staff did not consistently document patient pain assessments.
- Patient outcomes were variable compared to similar services.
- Processes were not in place to ensure that all staff received appraisals. Safeguarding and mandatory training was below trust targets. The trust were unable to provide assurance that registered nurses had undertaken specific competencies in order to care for children.
- The NHS Friends and Family Test (FFT) results were slightly worse than the England average and patient privacy was compromised at times in the second triage room.
- Governance, risk management and quality measurement processes were not robust. Governance meetings were in their infancy. There were no robust mechanisms for feeding back results of audit or results of the safety quality dashboard (SQD). Morbidity and mortality meetings were not held consistently. There was inconsistency between the risks that had been identified on the risk register and what staff said the risks were.
- Staff were not always involved in changes to the provision of services.

However:

- Patients and relatives spoke positively about the care they received. Staff treated patients with kindness and compassion and provided emotional support. Staff were friendly and professional in their interactions with patients and relatives and patients felt involved in their care and informed about the care they received.
- The service had accessed NHS Interim Management and Support (IMS) in order to review ways of working within the emergency department (ED) and improve the quality and efficiency of patient care.
- Staff administered medicines in a timely manner and advance nurse practitioners had undertaken further

Urgent and emergency services

training to be able to prescribe medicines. Staff ensured patients' nutrition and hydration needs were met, and patients were offered hot meals. Staff had good understanding of consent procedures.

- There was an electronic tool, which calculated the level of risk in ED this was used to monitor and escalate the level of risk. Staff had twice daily safety huddles and were seen to respond quickly and efficiently to emergency situations.
- Generally, care and treatment was planned and delivered in line with current evidence based guidance, and the service participated in some national audits.
- Staff worked collaboratively with each other and with other teams within the hospital to provide care that was coordinated and appropriate. The culture was friendly and supportive, staff worked as a team and local leaders were visible and approachable.
- Staff were aware of the trust's vison and consistently demonstrated the values of the organisation.

Are urgent and emergency services safe?

Inadequate

We rated safe as inadequate because:

- Systems and processes were not always reliable or appropriate to protect patients from avoidable harm.
- Staff did not consistently follow guidance to ensure patients were screened for sepsis or received sepsis treatment in a timely manner.
- There was no on call gastrointestinal bleeding (GI) rota to provide treatment anytime of the day or night.
- Patients were not always seen in 15 minutes by a registered healthcare professional. Staff did not consistently complete risk assessments for patients or escalate deteriorating patients appropriately.
- Whilst there was an incident reporting process in place, we were not assured that all incidents were reported, incidents were investigated in a timely manner or lessons were learnt and shared with all members of staff.
- Not all areas were clean and cleaning audits achieved less than trust targets. Not all staff decontaminated their hands and staff did not routinely submit hand hygiene audits. The trust were addressing hand hygiene audit submissions.
- No risk assessment of the environment to identify ligature points and minimise risks to patients had been undertaken.
- There were no ligature cutters or difficult airway trolley available. Emergency equipment was not checked in line with trust policy.
- There was no pharmacy support for staff and we found out of date medicines. Medicines fridge temperatures were not checked in line with trust policy and the medicine fridge in the emergency department (ED) was not working correctly.
- In the ambulatory care unit (AEC) records were not stored securely and there were delays in returning records to the medical records department.
- Safeguarding and mandatory training was below trust targets. The trust were unable to provide assurance that registered nurses had undertaken specific competencies in order to care for children.

- Consultant presence in the ED was less than the recommended 16 hours a day. Medical and nursing staffing was reliant on locum, agency and bank staff. However, the trust was actively addressing this.

However:

- Staff administered medicines in a timely manner and advance nurse practitioners had undertaken further training to be able to prescribe medicines.
- There was an electronic tool which calculated the level of risk in ED, which was used to monitor and escalate the level of risk.
- Staff had twice daily safety huddles and were seen to respond quickly and efficiently to emergency situations.

Incidents

- There were no never events reported between August 2015 and July 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- The emergency department (ED) reported 95 incidents between March 2016 and June 2016. The most frequently reported incident categories related to clinical care, lack of suitably trained or skilled staff and medicines management.
- Between March 2016 and June 2016, the trust reported seven serious incidents (SI) in urgent and emergency services. SI are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Of these, four occurred in the ED at Pilgrim Hospital. One resulted in the death of a patient and three resulted in 'severe harm'.
- We reviewed the SI report relating to the death of the patient. We saw the service had completed a root cause analysis (RCA) process in line with the National Patient Safety Agency (NPSA) guidance and action plans had been developed. However, we saw no evidence that learning had been shared with staff or actions had been taken to meet the duty of candour regulation. 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.
- We spoke with five members of staff, about the duty of candour regulation. All demonstrated a good understand of duty of candour and two members could give examples of conversations they had had with patients to explain when things had gone wrong.
- Staff reported incidents through the trust's electronic reporting system. All incidents were reviewed by the matron for the area and incidents were discussed at urgent and emergency services governance meetings.
- However, as of 12 October 2016, there were 270 incidents opened, 65 of these dated back to 2015. This meant staff had not completed reviews of these in a timely manner and any potential learning from the incident had not happened.
- All staff we spoke with understood their responsibilities and said they were encouraged to raise concerns and report incidents. Staff we spoke with could give us examples of recent incidents they had reported. However, staff within AEC did not report the late opening of the unit as an incident and we saw an example of patient who had delayed sepsis care, which had not been reported as an incident. We therefore could not be assured all incidents were reported appropriately.
- Of 11 staff members we spoke with about incident reporting, nine reported that they had not received feedback about the specific incident they had reported or general information about the themes from incidents. Staff could not give any examples of changes in practice that had resulted from incidents. We were therefore not assured there was a robust system in place to learn from incidents.
- Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. We saw evidence that mortality and morbidity meetings were held, but these were not held regularly. In the six months from April to September 2016, there had been three meetings, in April, May and July 2016. However, doctors, who attended the mortality and morbidity meetings, said the meetings were well attended, interactive and were a good learning experience.

Urgent and emergency services

Cleanliness, infection control and hygiene

- The Care Quality Commission (CQC) uses national surveys to find out about the experiences of people who use NHS services. As part of the CQC accident and emergency (A&E) survey (2014), questionnaires were sent to people who had attended an NHS A&E department during January, February or March 2014. Responses were received from 294 patients at this trust. The trust scored 'about the same' as other trusts for describing the department as clean.
- The ED had a dedicated team of cleaners, who were in the area every day from 7am to 1.30am. If areas needed cleaning outside these hours, staff told us they could access the theatre cleaning team.
- Staff used green 'I am clean' signed and dated stickers, to show equipment had been cleaned and was ready for use. Equipment was visibly clean.
- Most areas were visibly clean and tidy; however, there were three open shelves and one of the drawers for storing consumables in the resuscitation area was dusty. This was escalated to a senior nurse and the areas were cleaned immediately. The fridge in the patients' kitchen had a sticky substance on one of the shelves, the work surfaces were stained and surgical tape which was visibly dirty had been used to secure a notice. We observed this again on the unannounced inspection on 25 October 2016 and escalated this to the nurse in charge who advised us they would take appropriate action.
- Staff were required to complete cleaning checklists daily to indicate cleaning had been undertaken. We reviewed the checklists from 1 August to 14 October 2016 and saw these had been completed on 11 days. Therefore, there was no assurance that cleaning had been completed.
- The domestic supervisor and a member of the nursing staff undertook monthly cleaning audits. From August 2015 to July 2016, the trust target of 95% was met for two of the 12 months. For the remaining 10 months, results varied from 81-92%.
- We spoke with the senior nurse for the area, who had been in post for three weeks, they were aware that cleanliness was an issue and had identified it as a priority to address.
- Cleansing gel was available at the entrances to each area. Staff were 'bare below the elbow' to allow effective hand washing. We observed most staff washing their hands between patients; however, we saw five different staff on a total of 10 occasions fail to decontaminate their hands.
- All wards and departments were required to undertake monthly hand hygiene audits. However, from September 2015 to August 2016, ED only submitted results for March, July and August 2016. Results were between 93 to 95%. Ambulatory emergency care (AEC) submitted results consistently from November 2016, and achieved 100% for all months except May 2016 when they achieved 95%.
- Processes to address non-submission of hand hygiene data included the quality governance facilitator contacting the heads of nursing reporting those areas that had failed to submit audit data. Heads of nursing would cascade this information to their respective matrons, who were then required to follow up with ward leaders. Matrons were required to report hand hygiene audit data at the monthly infection, prevention and control site meetings. Within that forum, they would report their actions to support areas that had not submitted data. Following our inspection the trust told us a new method of collecting data was introduced in July 2016. The Service had consistently audited and submitted data since the new process was introduced and had reported pre –challenge compliance rates between 93% to 95%.
- As part of the safety and quality dashboard (SQD) the ED monitored the care received by patients who had a urinary catheter and who had a peripheral cannula. A urinary catheter is a tube inserted into a patient's bladder to allow drainage of urine. A peripheral cannula is a small tube inserted into a vein to allow the administration of medicines. Both can be associated with increased risk of infections for patients. Staff were required to label the peripheral cannula correctly after insertion. Results from the SQD show that from January to August 2016, this was completed on 16% of patients. Staff were also required to record care of the peripheral cannula on a specific chart; results from the SQD for the same period showed this was competed on 68% of patients. For the same period, only one patient with a urinary catheter was reviewed and result show that care had been given and recorded fully.

- There were no cases of clostridium difficile infections from January 2016 to June 2016. Clostridium Difficile is a bacterium affecting the digestive system; it often affects people who have been given antibiotics and can cause harm to patients.
- There were no cases of MRSA recorded between January and June 2016. MRSA is a type of bacterial infection and is resistant to many antibiotics.
- Protective equipment, such as gloves and aprons, was available and we observed staff using this appropriately.
- Two rooms, with doors, were available in the ED, which staff used to isolate patients who were at risk of spreading infection to others.
- Staff performed daily flushing of taps and showers to reduce the risk of Legionella. Legionella is a bacterium that can cause harm and can be found in water systems.

Environment and equipment

- The location of the ED was within a suitable distance of necessary supporting services for example, theatres, computed tomography (CT), and the helipad.
- In line with the intercollegiate standards for children and young people in emergency care settings (2012) there was a separate waiting room for children, which provided audio-visual separation from adults. However, this had recently been converted from a treatment room, and was not clearly identified as the children's waiting room.
- Staff spoke of their concerns regarding the size of the department. They felt it was not big enough given the number of patients accessing the department. On the afternoon of 13 October 2016, and on the evening of the 24 October 2106, we saw patients being cared for on trolleys in the central area as there were no free cubicles to use. This meant patient privacy and dignity was comprised and there was a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell.
- Staff within the ED had not considered the environment in relation to the risk of ligature points. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. No risk assessment of the environment to identify ligature points and minimise risks to patients had been undertaken. No ligature cutters, which are specially designed to offer an effective and safe method of cutting a ligature attached to a person, were available in the department, although tough cut scissors were available. Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response could be provided by the trust detailing how they were going to address our concerns to minimise risk to patients. In response, the trust provided a detailed plan outlining actions they intended to take. During our unannounced inspection on 24 October 2016, the nurse in charge of ED told us ligature cutters had been ordered, however these were yet to arrive. Staff told us in the meantime they would use tough cut scissors.
- There were safe arrangements in place to manage waste.
- There was a safe and effective system for the repair, servicing and maintenance of medical equipment. We checked 10 different pieces of medical equipment and found them to be in date with routine servicing.
- An anaesthetic machine was available for use in the resuscitation area of the department; staff had checked this daily.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Safety Guideline states that equipment for the management of the anticipated or unexpected difficult airway must be available in areas where patients receive an anaesthetic. Whilst this equipment was available in the resuscitation area, it was not stored in a dedicated difficult airway trolley (DAT). Having equipment stored in a dedicated standardised trolley makes it easier and quicker to access during an emergency. Nurses we spoke with were aware that the department was due to have a DAT, but were unsure as to when they would receive this.
- Resuscitation and emergency equipment for adults and children was available in ED and staff were aware of its location in the event of an emergency. However staff were not adhering to trust policy to ensure this was checked in line with the trust's policy.
- Adult resuscitation and emergency equipment was available at each bed space in the resuscitation area, and located on a trolley in the majors area of the department. Staff were required to check the contents of this trolley weekly. We reviewed the checklist and saw the checklist had not been signed for one of the six weeks between 30 August and 14 October 2016.
- Staff were required to check emergency equipment such as defibrillator, suction and oxygen daily. We

reviewed the checklists from 1 July to 13 October 2016 and saw that checks were not recorded for 11 days in September 2016, although checks were consistently recorded for the other months.

- Paediatric resuscitation was located on a trolley in the resuscitation area of ED. We reviewed the weekly checklist from 1 September until 23 October 2016 and saw there were two occasions where it was longer than a week between signatures. The checklist for recording the daily checks of the defibrillator, suction and oxygen was not available and staff could not locate it.
- Weekly checks of the resuscitation equipment in AEC had been completed. We reviewed daily checks of emergency equipment such as defibrillator, suction and oxygen and saw the checklist had not been completed for 20 and 21 October 2016.
- As part of the SQD, staff monitored if appropriate checks on resuscitation equipment had been completed. Results from January to August 2016, for ED showed appropriate checks had been completed for one of the six months.

Medicines

- Medicines were stored securely in ED. Controlled drugs (CDs) were stored in the resuscitation area and staff carried out twice daily checks on CDs in line with the trust policy.
- In the resuscitation area of the ED, we found three bags of out of date intravenous fluids. We reported this to a senior nurse who immediately discarded these and checked the remainder to ensure they were in date.
- Medicines in the AEC were stored securely. However, on our unannounced inspection on 24 October 2016, we found two packets of medicines that had expired in May 2016 and June 2016. There were no CDs stored in the AEC.
- There was no pharmacy support for staff in ED and AMC. This meant nurses spent time checking and ordering stock, which took them away from providing direct patient care.
- Staff were required to check daily the temperatures of medicine fridges to ensure medicines requiring storage between two and eight degrees centigrade were stored appropriately. Checklists for both medicine fridges in the resuscitation area of ED and AEC unit were not consistently signed. In ED, staff were required to perform checks daily. Checklists were only available for October 2016; these showed staff had recorded temperature checks for six of the 14 days. In AEC, checks were required every weekday. We reviewed the checklists between 1 August 2016 and 13 October and saw there were 27 days when temperatures checks had been recorded.
- The medicine fridge in the resuscitation area of ED was overstocked and medicines were not stored correctly within it to allow adequate airflow. During our inspection, the temperature gauge read 19 degrees centigrade and we could not be assured that the medicines held within the fridge remained fit for purpose. This was escalated to the nursing staff who told us that would be rectified. During our unannounced inspection on 24 October 2016, staff confirmed the fridge had been checked and was in working order. We reviewed the contents of the fridge and saw it was stocked appropriately and the temperature was in the correct range.
- As part of the SQD, staff monitored if fridge temperatures had been record daily. Results from January to August 2016, showed that this had not been achieved.
- As part of the SQD, staff monitored if medicines were administered within 30 minutes of request. For four months between January and August 2016, all medicines were administered within 30 minutes. For June 2016, 75% of medicines were administered within 30 minutes and for and 83.3% for July 2016.
- We looked at medicine administration records for four patients. The department used a paper-based system for prescribing and administering medicine to patients. Prescriptions were clear and records showed patients were getting their medicines when they needed them. Allergies to any medicines were recorded on all medicine administration records.
- Four of the nine advance care practitioners (ACPs) had undergone additional training in order to become non-medical prescribers. Non-medical prescribing is the prescribing of medicines and dressings by health professionals who are not doctors. This meant patients were seen and treated quicker as they did not have to wait to see a doctor.
- Registered nurses (RNs) were able to administer simple pain relief using patient group direction (PGDs). Patient group directions provide a legal framework to allow registered health professionals to supply and/or

administer specified medicines, to a predefined group of patients without them having to see a doctor. This meant that patient would receive their medication quicker.
- The CQC A&E Survey (2014) asked patients if staff explained the purpose of new medications and the side effects to them before they left the department. Results showed the trust scored 'about the same' as other trusts.

Records

- Staff used paper-based records. All staff recorded information in a pre-printed booklet, which aided communication between the professional groups.
- We reviewed 21 individual patient care records, all of which were accurate, up to date and legible.
- We reviewed the records of two patients who had been in ED for more than 6 hours and saw that staff had completed a pressure ulcer risk assessment, in line with best practice. However, data obtained from the SQD showed that from January to August 2016, an average of 21% of patients had a pressure area risk assessment completed, which meant that some patients may have been at risk of developing pressure damage.
- In the ED, records were stored in racks outside the patient cubicles, so were easily accessible for staff. Staff never left this area unattended, so records remained secure.
- In AEC patient records were kept in a mobile cabinet, by the nurse's station. Although this was lockable, staff said it was not locked during the time the unit was open. When patients were discharged, notes were moved to filing cabinets in the AEC office, which was also open. We were not assured staff would always be in these areas, which meant there was a risk unauthorised personal could access the records.
- In AEC there were 22 boxes of patient records being stored, waiting to be returned to the medical records department. Although these were stored securely, the delay in returning meant that medical records may not be available if the patient was readmitted under a different specialty.

Safeguarding

- The executive lead for safeguarding was the director of nursing who was supported by the deputy chief nurse. There was a named professional for safeguarding adults who was supported by a safeguarding practitioner. There was a named nurse for safeguarding children and young people also supported by a safeguarding practitioner.
- Staff received safeguarding of vulnerable adults training (level one and two) as part of their mandatory training. As of 31 August 2016, 38% of medical staff and 74% of nursing staff had completed level one training. Sixty-two percent of staff (medical and nursing combined) had completed level two training. This was below the trust target of 95%.
- Staff received safeguarding children and young people training (levels one, two and 3a) as part of their mandatory training. Completion rates for levels one, two and 3a were below the trust target of 95%. As of 31 August 2016, 38% of medical staff and 75% of nursing staff had completed level one training. Sixty-two percent of staff (medical and nursing combined) had completed level two and 65% had completed level 3a.
- Staff had clear procedures to follow if they had any safeguarding concerns or concerns that patients were at risk from domestic violence or female genital mutilation. Female genital mutilation (FGM) is defined as the partial or total removal of the female external genitalia for non-medical reasons. These procedures were clearly displayed at various points for staff to refer to.
- Staff were aware of the processes to follow to refer patients, where appropriate, to a Multi-Agency Risk Assessment Conference (MARAC). A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. Posters which provided information and advice for people experiencing domestic violence were displayed throughout ED.
- Staff we spoke with had a good understanding of safeguarding and could describe the actions they would take if they suspected a patient required safeguarding.
- Staff used a yellow 'SAFER' sticker for all children admitted to the emergency department. This sticker was based on the SAFER communication tool developed by the Department of Health guidelines, to provide a consistent approach to identifying and managing children at risk of abuse. Yellow SAFER

stickers were placed in the records of all children and were used by staff to record that potential abuse had been considered. We reviewed six children's records and saw that the yellow SAFER sticker had been completed.

Mandatory training

- All staff were required to complete mandatory training. This included topics such as fire safety, infection control, equality, diversity and human rights, information governance, health and safety slips, trips and falls, moving and handling, risk awareness, fraud awareness, and basic life support. The trust target for this training was 95%; however, this target was not met.
- As of 31 August 2016, completion rates for medical staff in the ED was 50% for all topics except basic life support which was 38%. However, doctors did have more advanced life support training. Eleven out of 15 doctors had completed either an advanced life support (ALS) or intermediate life support course (ILS).
- Not all doctors had current training in paediatric life support. Five out of 15 doctors had completed either advanced paediatric life support (APLS) or the European paediatric advanced life support (EPALS) courses.
- Completion rates for mandatory for non-medical staff, as of 31 August 2016 varied from 46% for basic life support to 88% for diversity and human rights.
- Some registered nurses (RN) had undertaken extra life support training; 74% of RN had either completed intermediate or advanced life support training.

Assessing and responding to patient risk

- The trust had an emergency department risk assessment tool. This was an electronic tool that calculated the risk of the department and rated it as either red, amber or green. Staff inputted data hourly, and the tool calculated the level of risk. This gave an 'at a glance' look at the number of patients in ED, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where the risk was.
- Bed management meetings took place twice a day to address and escalate risks which could affect patient safety such as low staffing and bed capacity issues. We attended the 3pm bed meeting on 13 October 2016 and saw the bed situation discussed and breaches over 4 hours escalated.
- Patients who attended the minors' area of the ED were first seen by the receptionist who took details and were then triaged by a dedicated triage nurse, who used a nationally recognised tool to prioritise patients.
- The triage area was located within the reception area and had a glass front. This meant that patients in the reception waiting area were visible to the nurse in triage. We saw the triage nurse respond quickly and appropriately to a patient sat in the reception area who became unwell.
- A registered healthcare practitioner should see all patients who attend the ED within 15 minutes of arrival. From September 2015 to August 2016, an average of 41% of patients received this initial clinical assessment within 15 minutes. However, this number had generally increased throughout the 12 month period; 27% of patients were seen within 15 minutes in September 2015, this had risen to 50% for August 2016.
- Patients who attended via ambulance were taken into the majors area and handed over to the ED staff. The nurse in charge allocated the patient to the appropriate area for example, waiting area, a major cubical or to the resuscitation area, depending on their clinical need.
- Information supplied by the local ambulance trust showed that from September 2015 to August 2016, out of 2210 patients, 20% were handed over to ED staff within 15 minutes. Fifty-six percent of handovers took place with 15 to 29 minutes, 15% of handovers took place within 30 to 59 minutes and 9% of handovers occurred after one hour. During our inspection, we observed six ambulance handover times, these varied between 17and 36 minutes.
- Senior leaders told us they were about to trial the allocation of a dedicated nurse to care for those patients who were waiting in corridor for a cubicle to be free. This was in order to respond to potentially deteriorating patients and improve patient experience.
- The ED had a rapid assessment and intervention team (RAIT). This meant that patients who attended the majors area of the department had an early assessment by a senior health professional and investigations and treatment initiated.
- Nursing staff used a national early warning scoring system (NEWS) and paediatric early warning scoring system (PEWS) to record routine physiological observations such as blood pressure, temperature, and

heart rate. Early warning scores facilitate early detection of deterioration by categorising a patient's severity of illness and prompting nursing staff to request a medical review at specific trigger points.

- The trust monitored monthly the compliance with NEWS/PEWS scoring and escalation of patients who had deteriorating scores. We reviewed Pilgrim A&E data from October 2015 to October 2016. No data was available for March and April 2016 due to the Trust undertaking a Trust wide Sepsis Campaign and the launch of the updated Sepsis Bundle. On average, 94.82% of patients observations were on time and complete; 89.92% of patients had the PEWS/NEWS score added correctly and 95% showed evidence of escalation for NEWS if required. The trust target for all four elements was 90%.
- The ED department had started to record observation electronically, however had reverted to using a paper based system to record observations, because the information technology and hand held devices were not available.
- The trust's policy stated that all patients with a NEWS of five or more must be screened for sepsis using the sepsis identification checklist and care bundle. Following this screening, if an infection was suspected, the sepsis six care bundle should be initiated. 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 swift delivery of 'basic' aspects of care prevents treatment that is much more extensive. One of the fundamental aspects of the sepsis six care bundle is to administer antibiotics within an hour of suspecting sepsis.
- Data provided by the trust for October 2015 to September 2016 showed that on average 63% of patients scoring a NEWS of 5 or more had the sepsis identification checklist and care bundle initiated. However, compliance varied month-to-month with the lowest compliance at 42% in July 2016 and highest of 78% in March 2016.
- Data for the same period showed that on average 35% of patients diagnosed with sepsis received antibiotics within one hour; however, compliance varied month to month with the lowest compliance at 26% in September 2016 and highest at 56% in March 2016.
- During our inspection, we reviewed the records of seven patients who had scored a NEWS of five or more. Of these, two were screened using the sepsis identification checklist and care bundle and received antibiotics within one hour. A further patient received appropriate care and antibiotics within the hour, although this was not recorded on sepsis identification checklist and care bundle.
- The remaining four patients did not receive appropriate care in a timely manner. Patients were either not screened or screened late and received antibiotics outside the hour period. In one case, the patient received antibiotics four hours 25 minutes after scoring a NEWS of eight. In another case, staff had not calculated the patients NEWS, which would have been seven.
- Results from the weekly sepsis audit were displayed in ED for staff to see. For week commencing 10 October 2016, the audit showed that eight patients' records were reviewed. Of these, five patients had the sepsis care bundle initiated and three of the eight patients received antibiotics within the hour; this meant that five patients did not receive antibiotics in an appropriate time frame.
- 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 wards and admission areas including ED. This included sepsis boxes in all areas, the introduction of a patient group direction (PGD) which provides a legal framework for nursing staff to administer antibiotics to a predefined group of patients without a doctor's prescription. Plans also included recruiting two full-time sepsis nurses, working in partnership with a local NHS ambulance provider and rolling 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.
- The ED had a consultant doctor and a registered nurse (RN) who acted as champions for sepsis care. We spoke with the RN who confirmed that they were due to start a programme of education for staff and was due to start attending the trust wide sepsis meeting.
- Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response

could be provided by the trust detailing how they were going to address our concerns to minimise risk to patients. In response the trust provided a detailed plan outlining actions they planned to take.

- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance for Gastrointestinal Haemorrhage: Time to Get Control (2015) states there must be a gastrointestinal bleeding (GI) rota to provide treatment anytime of the day or night, either on-site or as part of an agreement within a network of providers. 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. Guidelines were available (review December 2016) for the management of patients with upper gastro-intestinal bleeding however, staff did not demonstrate a consistent awareness of this.
- 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 a plan outlining actions they were going to take to address our concerns. The action plan did not set out clear steps as to how they were going to manage this risk 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 this included a transfer protocol agreed between physicians on all sites. In addition, there were plans to audit the outcomes of patients with a GI bleed. Plans to provide a GI bleed rota for February 2017 were still on going.
- Safety huddles took place twice daily at 8am and 3pm. The consultant doctor led the huddle and doctors, ACPs and the nurse in charge attended. The huddles used a standardised approach and details of the huddle were recorded on a handover checklist. We observed a huddle and saw that staffing was reviewed; staff discussed patient flow through the department and reviewed each patient.
- We observed a nursing handover and saw that risk such as patients with high NEWS were passed onto the next shift.
- Staff in ED referred to a trust wide patient transfer policy to ensure safe and timely transfer of patients; however, this policy was due for review in January 2018. Nursing staff accompanied patients appropriately, however, two nurses raised their concerns that whilst they were away from the department they were unable to provide care for the other patients who remained in the department.
- Staff responded quickly to the pre-alert/emergency phone and recorded information on a standardised form that ensured all key information was noted. Following such calls, we saw staff respond appropriately and prepare to accept patients. On one occasion, we saw a patient being immediately taken in to the resuscitation area.
- We saw staff respond quickly to emergencies, dealing with them calmly and appropriately.
- On one occasion, we saw a child who was acutely unwell admitted to ED; staff immediately contacted the paediatric emergency response team (PERT) who responded quickly and the child received appropriate care in a timely manner.

Nursing staffing

- Urgent and emergency services used the baseline emergency staffing tool (BEST) to plan nursing staffing requirements to ensure there was adequate cover of all areas including triage, minors and majors and resus across the full 24 hour period. The BEST has been designed to estimate emergency department (ED) nursing staffing requirements based on a combination of the number of patients attending the department, and a measure of the patients' nursing dependency.
- In order to strengthen the leadership of the department, there had been a recent increase in the number of senior sisters in the department, from three to 5.26 whole time equivalent (WTE).
- The Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings 2012 and Royal College of Nursing Standards 2013 state that a minimum of one paediatric trained nurses should work on each shift. There were two trained paediatric nurse employed in the ED, which was not sufficient to meet this standard. However, all registered nurses were required to undertake specific children's competencies. Paediatric nurses provided training to others in the department and we saw examples of the training materials used. We asked the trust to provide details of how many nurses has completed specific children competencies but they were unable to provide this information.

- Bank and agency nurses were used to maintain staffing levels in ED. From April 2015 to March 2016, the average bank / agency use was 40%.
- Between March 2016 and May 2016, an average of 78% of registered nurse day shifts were covered. For June 2016, this had improved to 92%. For the same period, at least 94% of registered nurse day night shifts were covered.
- Agency nurses were orientated and an induction checklist completed, which included for example explanation of the bleep system and cardiac arrest procedure. We saw evidence that these had been completed.
- Senior leaders told us that agency nurses were 'block booked'. This meant that the same nurse was booked for a period of time and helped provide a more stable work force.
- As of September 2016, the ED was funded for 42 (WTE) RN posts. There were 25.7 WTE RN in post, which meant there was a vacancy of 16.3 WTE. There was a vacancy of 3.3 WTE health care assistants (HCA) posts.
- As of September 2016, there were no vacancies for either RN or HCA in the AEC.
- Senior leaders told us they were actively recruiting nurses, and were looking at alternatives such as appointing paramedics. They told us they were due to implement the role of the nursing associate. Nursing associates work under the supervision of a RN, but have greater skills and knowledge than the of the traditional HCA role.
- Staffing in the ED consisted of between seven and nine RN and two or three HCA depending on the time of the day, with more staff rostered on in the afternoon and evening when the department was busier.
- Staffing in the AEC unit comprised of four registered nurses and two HCA in the morning and three RN and two HCA in the afternoon.
- Nursing handovers took place twice a day at change of shift. We observed one handover and saw staff hand over information appropriately to ensure patients were kept safe.

Medical staffing

- A consultant was present in the department from 8am to 9pm. This was less than the recommendation of 16 hours per day. At weekends, a consultant was present for seven hours a day, between 9am to 4pm. Outside of these hours there was a consultant on call.
- Middle grade and junior doctors were present 24 hours every day.
- The department had funding for 11 WTE middle grade doctors posts, but as of September 2016, five WTE were in post. The short fall in middle grade doctors was covered by doctors doing additional shifts, locum and agency staff. Senior managers recognised they had difficultly recruiting in to middle grade posts because they did not provide a formal certificate of eligibility for specialist registration (CESR) pathway. CESR provides doctors with training and experience in order to progress to consultant posts. We saw a proposal that was presented to the executive team in September 2016 to increase the number of middle grade doctors to 18 WTE and offer CESR training posts in order to attract middle grade doctors and support their development into consultant roles. This would also provide a more stable work force and reduce cost of agency workers.
- Junior and middle grade doctors told us they were supported by more senior colleagues, and were always happy to ask for help.
- Medical handovers took place twice a day as part of the safety huddles. Handover was led by the consultant doctor using a standardised approach. We observed a huddle and saw that doctors handed over information appropriately to ensure patients were kept safe.

Major incident awareness and training

- The trust had a major incident policy, which detailed specific actions staff in the ED needed to take in the event of a major incident.
- Information regarding actions to be taken in the event of a major incident were displayed on a notice board, within ED. These listed for example, the action to be taken by the nurse in charge should a major incident occur. No action cards for major incidents were available. This was escalated to a senior nurse, who ensured that action cards were printed and we saw this had been completed by the end of the day. On our unannounced inspection on 24 October 2016, we saw action cards were readily available in the major incident room.
- Major incident alert forms were located next to the emergency phone so staff could easily record details of a major incident should it arise.

Urgent and emergency services

- The department had access to decontamination facilities and equipment to deal with patients who may be contaminated with chemicals, exposure to nuclear and other hazardous substances.
- The trust underwent an emergency training exercise in June 2015. As part of a Public Health England (PHE) funded programme. The aim of the training was to test the major incident plan in response to a simulated mass casualty major incident. The report of the exercise identified ED achieved a total of 31 out of a possible 36 and demonstrated good teamwork, communication and organisation.
- Security staff were not located in the department, but could be called if required.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because:

- Patient outcomes were variable compared to similar services and some standards were not measured or audited.
- Staff did not consistently document patient pain assessments.
- Processes were not in place to ensure that all staff received appraisals.
- Mental capacity and best interest decision decisions were not consistently recorded.

However:

- Staff generally followed guidelines with the exception for those relating to sepsis care.
- Generally, care and treatment was planned and delivered in line with current evidence based guidance, and the service participated in some national audits.
- Staff worked collaboratively with each other and with other teams within the hospital to provide care that was coordinated and appropriate.
- Staff ensured patients' nutrition and hydration needs were met, and patients were offered hot meals.
- Staff had good understanding of consent procedures.

Evidence-based care and treatment

- Procedures, policies and clinical guidelines were easily accessible through the trust's intranet. Staff demonstrated that they could locate and find these easily. However, the policy for antimicrobial prescribing was due for review in May 2016.
- Generally, staff provided care in line with national recommendations. For example, care provided by the advanced care practitioners (ACP) reflected national guidance. These included, for example care for shoulder injuries and simple fractures. Laminated copies of these guidelines were easily accessible for the ACP.
- The deep vein thrombosis (DVT) clinic, situated in the ambulatory emergency care unit (AEC) unit provided care for patients in line with guidance from National Institute of Health and Care Excellence (NICE).
- Patients admitted with trauma were cared for in line with guidance from the regional major trauma centre.
- However, during our inspection we saw that staff did not consistently follow some guidelines, for example, sepsis screening and care.
- Care bundles were available for staff to use. These provided details of the care that was required in line with recognised guidance and provided a proforma to document the care staff had given. Examples of care bundles included care of a patient with possible hip fracture and care of patient with head injury. During our unannounced inspection on 24 October, we saw two patients who had suffered a head injury, both of these had received the care in line with the guidance, but the proforma had not been used to record this care. There were no local audits conducted, to monitor the use of the care bundles.
- We spoke to two doctors who were aware the rights of patients subjected to the Mental Health Act Code of Practice.
- The department had a local audit plan for 2016/17 which included reviewing safeguarding practice with the department, calls to trauma team, care of patients with venous thromboembolism (VTE) (formation of blood clots in the veins) and the monitoring of vital signs in children.
- Doctors were aware of the department's participation in national audit and told us there were audit meetings once a month.
- The nurse in charge of the emergency department (ED) completed the safety and quality dashboard (QSD) assurance records. These required the nurse to review the care for two patients to determine, for example, if

documentation had been completed appropriately and observations had been performed. The nurse was also required to audit staff compliance with handwashing, and cannula insertion and to audit if safety checks of medicine fridges, controlled drugs (CD) and resuscitation trolleys had been completed. Staff we spoke with said the safety and quality assurance records were currently being completed on two patients every day. However, we reviewed the assurance records for September and October 2016, and saw completed records for 5 days in September and on the 7 and 10 October 2016.

Pain relief

- Staff used a pain score of zero to 10 to assess a patient's pain. However, staff did not consistently record pain scores. Results taken from the ED safety and quality dashboard (SQD), showed on average from January to August 2016, pain scores were recorded on 33% of patients.
- We reviewed six adult patient records and saw staff had documented pain scores for two patients. We reviewed the records of four children and saw staff had documented pain scores for three children.
- The Royal College of Emergency Medicine (RCEM) Management of Pain in Children guidelines requires that children are offered pain relief within 20 minutes, and that this is audited. The department did not undertake this specific audit, but did review, as part of the ED SQD, if all patients were offered pain relief within 15 minutes. We reviewed the data for January to March 2016 and July to August 2016, as no data had been submitted for June 2016. On average, 76% of patients were offered pain relief within 15 minutes.
- However, we observed staff asking patients about their pain and offering and administering pain relief appropriately.
- The CQC accident and emergency (A&E) survey (2014) asked patients if they had a long wait to receive pain relief if requested it and asked if they felt staff did all they could to help control their pain, if they were ever in pain while in A&E. For both of these questions the trust scored 'about the same' as other trusts.

Nutrition and hydration

- The CQC A&E Survey (2014) asked patients if they were able to access suitable food and drink while in A&E, if they wanted to. Results showed that the trust scored 'about the same' as other trusts for this question.
- A small kitchen area was located in the department, so staff could easily provide drinks and snacks, such as sandwiches, to patients.
- A water dispenser and bottles of squash were available in the main area of the department and a water dispenser and vending machine was available in the waiting room.
- At the time of our inspection, the department was trialling the introduction of a hot meal for those patients who were able to eat at lunchtime, and we saw patients being asked if they would like to eat at lunchtime.
- We saw staff providing hot drinks and snacks to patients throughout the day. Patients confirmed staff had offered drinks and snacks.

Patient outcomes

- The trust had one open mortality outlier alert. This is when there have been a higher number of deaths than expected for a defined condition. The trust received notification from Dr Foster Intelligence that they had shown a higher than expected hospital standardised mortality ratio (HSMR) in the area of sepsis. Dr Foster Intelligence is a provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service and providing information to the public.
- The service participated in national audits such as the Royal College of Emergency Medicine (RCEM) audits in order to assess their practice and performance against best practice standards.
- In the 2014/15 RCEM audit for initial management of the fitting child, the ED performed better than other trusts for four of the six measures. The ED met the fundamental standard of checking and documenting blood glucose for the fitting child.
- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, the ED was in about the same as other trusts for four of the six measures. The trust did not meet the fundamental standard of having an early warning score documented.
- In the 2014/15 RCEM audit for mental health in the ED, the ED was worse than other trusts for five of the six measures. Of the two fundamental standards included

in the audit, the trust did not meet the fundamental standards of documented risk assessment standard and a dedicated assessment room for mental health patients.

- We reviewed the action plans from three further RCEM audits that were performed in 2015/6. These were the vital signs in children audit, the venous thromboembolism (VTE) audit and the procedural sedation in adults. We saw that whilst actions had been taken, staff in the ED were unaware of these. For example, the service told us as a result of procedural sedation in adults it had developed a proforma for the use of sedation and a patient information leaflet. However, staff in ED were not aware of this and the patient information leaflet could not be found.
- The trust did not partake in the RCEM consultant sign-off audit. This meant they were unable to provide assurance that a consultant review prior to discharge occurred in the following four high-risk patient groups. The four high-risk groups are, atraumatic chest pain in patients aged 30 years and over, fever in children under one year of age, patients making an unscheduled return to the ED with the same condition within 72 hours of discharge and abdominal pain in patients aged 70 years and over.
- Between May 2015 and April 2016, the unplanned re-attendance rate to ED within seven days was 6.9%. This was worse the national standard of 5%, however, better than the England average of 8.7%.

Competent staff

- Not all staff had received an annual appraisal. For all non-medical staff, 39% had received an appraisal for the 12-month period ending July 2016. However, 90% of doctors have received an appraisal for 2015/16.
- From April 2016, all registered nurses were required to revalidate every three years with the Nursing and Midwifery Council (NMC) in order to continue practising. Registered nurses demonstrated a good understanding of the requirements needed and we saw posters in the staff room of ambulatory emergency care (AEC) providing staff with information about revalidation.
- Staff we spoke with told us there were training opportunities available but it was difficult to attend due to staffing levels. Staff we spoke with said they had received local training, for example in order to triage, and updates on caring for patients with burns. A dedicated website was available where resources and training material from study days could be accessed.
- Minutes from the emergency care senior nurse meeting in June 2016, and the senior nurse/ ACP meeting in September 2016, demonstrated that the education and training requirements of nurses in ED was reviewed and monitored.
- In ED, there were nine ACPs, who were registered nurses or paramedics, who were supported to undertake further training, which enabled them to independently see and treat patients with minor injuries. This meant patients could be seen quicker and did not have to wait to a doctor.
- There was a network of link nurses or champions for specific areas of care such as infection prevention and control and sepsis. These acted as a resource and provide advice to other staff.
- Registered nurses had undertaken training to care for trauma patients; 71% of RNs had completed either the advanced trauma nursing course or the trauma intermediate life support.
- The trust informed us that 13 staff from the ED had completed online sepsis training. However, they did not supply this as a percentage of staff that required training, or provide details as to which staff groups had completed it.

Multidisciplinary working

- There was effective multidisciplinary team (MDT) working and communication between the MDT within the ED.
- MDT huddles took place twice a day to ensure all staff had up-to-date information about risks and concerns.
- There was effective team working with other teams in the hospital. We saw effective teamwork between ED staff and the paediatric emergency response team (PERT) when caring for a critically ill child in the ED.
- There were good links with other departments in the hospital for example x-ray, with doctors confirming they could get support from radiologists if required.
- Specialist cardiac assessment nurses (CAT) were available to support and review patients with heart conditions, these were available from 8am to 8pm, seven days a week.

Urgent and emergency services

- There was no alcohol liaison service available in ED. However, staff were aware to refer patients to a national drug and alcohol treatment charity.
- We observed good interaction and communication by staff handing over care to other specialities.
- When patients were discharged, reception staff generated letters from the department's electronic system; these were printed off and posted to the patient's GP. doctors did not review or sign off letters. However, this meant they were sent to the patient's GP very quickly???

Seven-day services

- The ED provided a service 24 hours a day, 365 days a year. The ambulatory emergency care (AEC) unit was open from 8.30am to 10pm, five days a week; however, staff told us this was due to open 24 hours a day, seven days a week from 31 October 2106.
- The NHS Services Seven Days a Week Priority clinical standard 2 requires all patients are seen by a consultant as soon as possible, but at least within 14 hours of arrival. The department monitored compliance with this and provided evidence that in September 2016 88% of patients were seen and assessed by a suitable consultant within 14 hours of admission.
- Clinical standard 5 required that patients have timely access to diagnostics such as x-rays and CT scans; however, the department did not monitor this, so we could not be assured this standard was being met. Following our inspection the trust told us the radiology department monitored compliance against Clinical Standard 5.
- Support services such as X-ray, pathology and theatres were available 24 hours a day.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There was a formal handover for patients transferred from the department to the wards, which included a summary of the patient's care and treatment in the department. A copy of the patient records accompanied the patient to the ward on transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated understanding of the issues around consent, and without exception, we saw staff obtaining consent prior to all interventions.
- Medical staff demonstrated an understanding of the consent process for children and young people and told us they would refer to the Gillick competency and Fraser guidelines. Gillick competency and Fraser guidelines are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.
- We asked the trust to provide information as to how many staff had received training on Gillick competency and Fraser guidelines. However, they did not provide this information.
- Staff demonstrated some understanding of the Mental Capacity Act 2005. If a person 'lacks capacity' in relation to a matter, then other people can make decisions for them in their 'best interests'. We saw staff seek advice from others including family members so decisions could be made in the best interests of the patient. We reviewed one patient record where consideration had been documented regarding the patient's capacity. However, we reviewed the record of one patient who lacked capacity and saw that no best interest decision had been recorded.
- We asked the trust to provide information as to how many staff had received training on consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. However, they did not provide this information.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- Patient and relatives spoke positively about the care they received.
- Staff treated patients with kindness, compassion and provided emotional support.
- Staff were friendly and professional in their interactions with patients and relatives.
- Patients felt involved in their care and informed about the care they received.

However:

- The NHS Friends and Family Test (FFT) was slightly worse than the England average.
- Patient privacy was compromised at times in the second triage room.

Compassionate care

- Following our inspection, we reviewed information from 12 comment cards completed by patients and relatives before our inspection. Responses were mixed, with 50% reporting a negative experience whilst in an emergency department (ED) at this trust. We were unable to determine from the comments cards which hospital the patient or relative had attended.
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients' satisfaction with the healthcare they have received, and how likely they are to recommend the service to their friends and family. From September 2015 to August 2016, 77 to 84% of patients would recommend the service. This was slightly worse than the England average of 84 to 88% for the same period. However, we spoke with 11 patients and eight relatives. All were positive about the care they or their relatives received.
- As part of the safety and quality dashboard (SQD) staff monitored monthly if curtains were used appropriately, if patients' modesty was maintained, if patients reported good communication from staff and if staff introduced themselves. From January to August 2016, scores were consistently 100% for all these aspects of care.
- Staff treated patients as individuals; patients were addressed by name and staff introduced themselves prior to providing care.
- Patients told us, all staff treated them with kindness and compassion and our observations supported this.
- Staff took time to speak with patients and did so in a friendly and professional manner.
- We saw staff using different approaches to talk to children and young people and they spoke directly to them during consultations and assessments.
- Staff respected patients' privacy and dignity. Staff always drew curtains round cubicles or closed doors whist examinations were in progress and used blankets to protect patients' modesty. However, in order to access patient records from reception, the triage nurses needed to walk through the second triage room, which if in use at the time compromised the patient's privacy.
- Patients told us they felt safe and had confidence in the care they received.
- As part of the NHS hospital inpatient survey in July 2015, patients were asked if they were given enough privacy when being examined or treated in A&E. Trust wide results showed that the trust scored about the same as other trusts for this question.

Understanding and involvement of patients and those close to them

- The CQC A&E Survey (2014) survey asks patients if they were told how long they would wait to be examined and if they felt they had enough time to discuss their problem with a doctor or nurse. It also asks if they felt the doctor or nurse explained their condition and treatment in a way they could understand, listened to what they had to say, and if family had the opportunity to talk to a doctor if they wanted to. Additionally, it asked patients if they felt they had been given the right amount of information and if they were involved as much as they wanted to be in decisions about their care and treatment. Results showed that that the trust scored 'about the same' as other trusts for these questions.
- Patients and relatives told us they felt informed about the care they were receiving. We observed staff explaining what was happening in a way patients could understand. Procedures were explained step by step.
- Patients felt included in the decision making process and were kept up to date with what was happening. We observed staff returning to patients and updating them with test results appropriately.
- Staff checked that patients and relatives had understood the information they had been given and asked if they had any questions.
- Patients were asked if they were given enough information about their condition and treatment when being examined or treated in A&E as part of the NHS hospital inpatient survey in July 2015. Trust wide results showed that the trust scored 'about the same' as other trusts for this question.

Emotional support

- We saw staff providing reassurance for patients who were anxious. This included a nurse spending time with a patient, who was upset because they could not go home. The nurse took time to sit with this patient and explain why they needed to stay.

- We saw a nurse offer comfort to the spouse of a patient who had been admitted to the resuscitation area, by holding their hand and explaining in a calm way what was happening.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We rated responsive as requires improvement because:

- Patients were not always admiited, transferred or discharged within four hours. From September 2015 to August 2016, 61% of patients were admitted transferred or discharged within four hours.
- The service had not taken steps to address the accessible information standard. There was no hearing loop available at reception.
- Despite the local area having a large population of people from Eastern Europe, information was only provided in English.
- The environment was not "dementia friendly," there were no facilities or equipment that could help support patients living with dementia.

However:

- The service worked with other organisations to ensure that patients were not admitted to hospital unnecessarily.
- The service worked closely with other NHS trusts to provide care to patients with learning disabilities and those with mental health needs.
- Themes from complaints were reviewed, shared with staff and used as an opportunity to learn.
- The number of patients waiting between 4-12 hours from decision to admit to actual admission, was better than the England average.

Service planning and delivery to meet the needs of local people

- The service worked closely with the local authority to provide support for patients to avoid unnecessary admission to hospital. Staff from the local authority were based in the emergency department (ED) and could support patients to return home by providing packages of care.
- A neighbouring NHS trust provided an in reach community service. This supported people to return home, rather than being admitted to hospital. The service provided support from physiotherapists and occupational therapists in the patient's own home.
- Senior leaders told us they had just secured funding for a frailty unit to be located elsewhere in the hospital. This was due to open on 1 November 2016 and would contain eight beds. Elderly frail patients would be assessed and cared for more appropriately in the frailty unit rather than in the ED.
- There was adequate space and seating in the reception area for patients.

Meeting people's individual needs

- From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the accessible information standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with health and social care services. The service had not taken steps to address this standard.
- The reception desk was screened off by a window, which staff needed to open to speak to patients. We saw that patients needed to lean through the open window in order to be heard. Staff told us it was often difficult to hear patients and there was no hearing loop available.
- Staff were able to access a translation service at any time. A double handset telephone was available so conversation could be translated easily between patients and staff. We saw staff using this service to explain to a parent about the care their child needed. All patient information and posters were in English. Staff told us there were a high numbers of patients from Eastern Europe; however, information was not available in any Eastern European languages.
- The matron for the department was aware that the environment was not ideal for patients living with dementia and spoke of plans to address this. These included providing support to patients by making a dementia friendly cubicle, by obtaining reminiscence books and twiddle muffs, (which are designed to

provide a stimulation activity for restless hands) and provide education and training for staff. If patients living with dementia were unaccompanied and were distressed staff attempted to provide one-to-one care. On two occasions, we saw a health care assistant (HCA) sit with patients who were living with dementia in order to provide reassurance.

- Support for patients with mental health needs was provided by a neighbouring trust who were based within the unit and were available from 8am to 8pm**.** The department had access to child and adolescent mental health services (CAMHS) 24 hours a day, seven days a week, to support children and adolescents with mental health needs. Staff confirmed they used this service which was responsive.
- A telephone referral system was in place for staff to access one of two learning disability specialist nurses employed by a neighbouring mental health trust. The trust did not monitor how many patients with a learning disability were accessing services. Staff spoke positively about the support received from this service.
- We observed a member of staff support a relative with sight impairment; once the staff member had transferred the patient to the cubicle they returned to guide the relative and supported them to sit in the chair.
- There was a designated room for relatives, which offered privacy if required. Toys for younger children were available in the children's waiting room.
- Bariatric trolleys were available in ED.
- Accessible toilets were available and there was a lower desk in the reception area for wheelchair users.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. From September 2015 to August 2016, 61% of patients were admitted transferred or discharged within four hours, which meant that the department was not meeting this target.
- Between September 2015 and August 2016, 11% of patients remained in the department for over six hours; No patients waited longer than 12 hours. The average time a patient spent in the ED was three hours and 23 minutes.
- Between September 2015 and August 2016, less than two percent of patients waited between 4-12 hours from decision to admit to actual admission, this was better than the England average.
- Between September 2015 and August 2016, three percent of patients left the department before being seen. This was better than the England average.
- As part of the CQC accident and emergency (A&E) survey (2014), patients were asked if they felt they had spent too long in A&E. Results showed the trust scored 'about the same' as other trusts for this question.
- The service was taking action to improve the flow throughout the department and reduce the times people were waiting.
- Waiting times were displayed on an electronic board in the reception area to keep patients updated.
- Staff monitored patient flow electronically; all patients were recorded on a large touch screen so staff could see at a glance how long patients had been in the department.
- Bed management meetings took place twice a day to address and escalate risks that could affect patient safety such as low staffing and bed capacity issues. We attended the 3pm bed meeting on 13 October 2016 and saw the bed situation discussed and breaches over 4 hours escalated.
- The ED had an action plan in place called the emergency care recovery programme in order to address the issues with flow and capacity in ED. We reviewed this action plan following our inspection and saw actions included liaising with GP to ensure GP referrals to ED were appropriate, reviewing process across medical wards to maximize the number of beds available for patients who required admission as well as actions within the ED itself.
- Actions in ED included the introduction of a nurse in charge, to have an overview of the department and direct patient flow through the department. Another action that was in progress was providing further education and training to triage nurses, so they could request x-rays in order to reduce the waiting times for investigations.
- In addition to the action plan, in October 2016 the trust had introduced new emergency care principles in response to the increased demand in the service. The principles included improved working with speciality teams within the hospital in order for patients to be transferred quicker to the speciality team.

- The ED had a rapid assessment and intervention team (RAIT). This meant a patient arriving in the major's area was assessed by a senior doctor who was able to make a complete initial assessment and order investigations or start treatment or investigations immediately. Patients were not delayed by having an initial assessment by a junior member of staff.
- The use of the ambulatory emergency care unit (AEC) meant that patients who were suitable were cared for in this unit, in order to free up space in the ED. Patients, who arrived in ED, were assessed using strict criteria and if suitable would be taken straight through to AEC for treatment.

Learning from complaints and concerns

- Complaints relating to the ED were raised through the patient advice and liaison service (PALS). Staff were aware of their responsibilities to help patients to complain and would signpost patients to PALS. However, no posters or leaflets were visible to provide patients with this information.
- We spoke with one patient who told us they would feel happy to raise any concerns with a member of staff and was confident this would not have detrimental effect on the care they received.
- From June 2015 to May 2016, the ED received 80 complaints. The top three themes for complaints related to clinical treatment, communication, and admission and discharges. Staff we spoke with were aware of these themes. Staff reviewed complaints at the newly instigated governance meetings and patient experience was shared with staff in the emergency care newsletter.
- Senior leaders told us that as a result of complaints they had provided all doctors with uniforms so patients could identify the staff groups easier. Additionally, personalised name stamps had been issued to all staff to use after recording information in patients records. This helped the investigation of complaints as it was clear who had cared for that patient.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Governance, risk management and quality measurement processes were not robust. Governance meetings were in their infancy.
- There were no robust mechanisms for feeding back learning from incidents and reviews of incidents were not completed in a timely manner.
- There were no robust mechanisms for feeding back results of audit or results of the safety quality dashboard (SQD). Morbidity and mortality meetings were not held consistently.
- There were inconsistencies between the risks that had been identified on the risk register and what staff said the risks were.
- Staff were not always involved in changes to the provision of services.

However:

- Staff were aware of the trust's vison, and consistently demonstrated the values of the organisation.
- The service had accessed the NHS Interim Management and Support (IMS) in order to review ways of working within the emergency department (ED) and improve the quality and efficiency of patient care.
- The culture was friendly and supportive, staff worked as a team and local leaders were visible and approachable.

Vision and strategy for this service

- The Trust had a five year strategy for all clinical services for 2014 to 2019 to support the delivery of good quality patient care. The vision and strategy for urgent and emergency care was to provide a consultant-led service 24 hours a day, seven days a week in order to improve medical care and facilitate timely treatment across Lincolnshire County. This was in line with recommendations from the 2013 Keogh urgent and emergency care review (a comprehensive review of the NHS urgent and emergency care system in England). Particular emphasis was to be placed on services that were time critical, ensuring patients had rapid access to urgent care in the right place, when they needed it.
- The senior leadership team, told us of plans to meet the vision and strategy for urgent and emergency care. Plans included, for example, increasing the nursing and medical establishments in the emergency department (ED) and developing closer working relationships with the frailty team.

- The trust's vision was to provide sustainable high quality patient-centred care for the people of Lincolnshire. This was underpinned by five key values: services will be patient-centred, patient safety and well-being is above everything, strive for excellence, offer patients compassion and show respect for patients and for each other. Most staff were aware of this vison.
- Without exception, all staff demonstrated the trust's values in their day-to-day work, both when caring for patients and their families and when interacting with colleagues.

Governance, risk management and quality measurement

- The emergency department (ED) had just reinstated the monthly clinical governance meetings in August 2016; prior to this, the last meeting was October 2015. We reviewed the minutes from September 2016 and the governance report from the October 2016 meetings. These demonstrated that the meetings were multi professional and sepsis audit results, serious incidents, risks, patient experience and the safety and quality dashboard (SQD) results were discussed.
- There were no robust procedures for feeding back learning from incidents, results of audit or results of the SQD and staff we spoke with were unaware of the results of these.
- We were not assured that learning occurred as a result of incident reporting. Staff told us that they did not receive feedback or could not give examples of changes in practice as a result. Reviews of incidents were not completed in a timely manner.
- However, from September 2016 senior nurses had started to produce a monthly newsletter, which contained feedback on some quality assurance information such as hand hygiene and controlled drugs (CD) audits.
- From September 2016, senior nurses within ED had started to meet; September's minutes demonstrated that staff discussed risks such as staffing levels and sepsis care as well as feedback from complaints.
- Senior nurses had quarterly meetings to discuss learning across the three ED departments in the trust. Minutes from the meeting in June 2016, demonstrated that staff had discussed governance issues such as staffing and results from audits.
- There were inconsistencies between the risks that had been identified on the risk register and what staff said the risks were. We reviewed the risk register for ED, which was sent to us before our inspection. There were three risks identified for the ED. These were nurse vacancies, reduced access to the cardiac assessment nurses and lack of pharmacy support. However, when we spoke with senior leaders and senior nurses in ED about the risks, they stated the risks were nurse and doctor vacancies, overcrowding and lack of capacity and sepsis care.
- The trust used the SQD to provide assurance for various aspects of care. However, we saw that some aspects of care were consistently scoring low for example, checking of emergency equipment. We were therefore not assured that appropriate actions were being taken to address this.
- Morbidity and mortality meetings were not held consistently, which meant there was no robust process to review and discuss individual cases and identify any learning from these.

Leadership of service

- The emergency department was part of the medical directorate. The overall lead for the emergency department was the clinical director, who was supported by the clinical lead for the department and head of nursing for the directorate.
- The head of nursing and matron for the department were new in post and staff commented that these recent changes had been unsettling. The previous matron had only been in post a few months. However, there had been a three week hand over period between the outgoing and incoming matron, in order to promote continuity.
- The advanced care practitioners (ACPs) across all three EDs had met to look at how they could develop the workforce through urgent and emergency services at this trust. The team had met for the first time in September 2016 and we saw minutes from this meeting demonstrating their commitment to improving services within the ED.
- Staff we spoke with said they were supported by their line managers and that local leaders were visible and approachable.
- There was a senior nurse who coordinated each shift and managed the day-to-day running of the department.
- Staff on the ambulatory care unit AEC told us as from 31 October 2016 the AEC would be open 24 hours a day,

seven days a week. Staff were upset about this as they had been informed by email, the week before, with no consultation and were concerned as to how they unit would be staffed. This had impacted negatively on the morale of the staff.

Culture within the service

- Staff told us the culture was friendly and supportive and they were most proud of the teamwork in the department. Many said the team was like a big family, everyone worked hard, and everyone valued each other and looked after each other.
- Nursing staff said that morale had been low, due to the workload and levels of staffing, but this was improving. Senior nurses felt there had been a noticeable improvement in attitudes of staff and that staff were positive and now had a 'can do' approach.
- Whilst staff understood about candour, openness and honesty when things went wrong. None of the staff we spoke with had received any formal training related to duty of candour.
- Senior nurses in ED felt respected and valued by service leads and the wider trust executive team. They told us the chief nurse was supportive and there was regular communication from the CEO through a monthly newsletter.

Public engagement

- The ED engaged with patients and their relatives to gain feedback from them. Patients were sent text messages to provide feedback. Feedback forms were also available for patients to complete.
- Healthwatch Lincolnshire completed 'mystery shopper' visits the ED sites, between 11 to 29 July 2016. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care. Feedback from these included comments regarding the environment and access, for example. The service had developed an action plan as a result and we saw evidence that some of the actions had been completed such as redesigning the triage area, in order for patients in the waiting area to be visible to the triage nurse.

Staff engagement

- From September 2016, the service had introduced a monthly newsletter in order to provide staff with an update as to what was happening in the service.
- The staff in ED used social media to share information. These were private groups, which only staff could access, where staff could share information such as training dates or swapping shifts.
- Staff had introduced a 'shout out' board in ED. This was where staff could recognise and thank their colleagues by writing messages on post it notes and displaying these on the board.
- However, staff said they were not aware or consulted about changes to the running of the department. For example, staff had not been involved or consulted in the changes in the opening times of the AEC, nor had been consulted in the introduction of the new emergency care principles.

Innovation, improvement and sustainability

- The service had obtained support from the NHS Interim Management and Support (IMAS). NHS IMAS offers NHS organisations that need short or medium term support, access to management expertise that exists throughout the NHS. This provided the ED with intensive support from a senior experienced nurse, who provided leadership to review ways of working in ED in order to the improve quality and efficiency of patient care. Changes as a result of this support had included the relocation of the triage area so that patients in the reception waiting area were visible to the nurse in triage, and trialling a dedicated nurse to care for those patients waiting in the corridor area.
- The service had developed the emergency care recovery programme action plan and introduced the emergency care principles in order to improve the sustainability of the service.

Medical care (including older people's care)

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

Information about the service

United Lincolnshire Hospitals NHS trust provides medical care (including older people's care) at Pilgrim hospital which is located in Boston. Medical care is part of the integrated medicine business unit and is led by a clinical director, head of nursing, a senior business manager and two matrons. In addition, a head of service represents medicine for each of the clinical specialities.

The trust has 546 inpatient medical beds across the two sites (Pilgrim and Lincoln); 209 beds are located at Pilgrim hospital. The services include care of the elderly medicine, clinical oncology, respiratory medicine, gastroenterology, cardiology, stroke medicine and general Medicine.

Between March 2015 and February 2016, there were 23,423 medical admissions at Pilgrim hospital. During our inspection, we visited 10 clinical areas. These included the acute medical unit (AMU), wards 6A, 6B, 7A, 7B, 8A, 9A, coronary care unit, discharge lounge and the endoscopy unit.

During our inspection of this hospital, we spoke with 10 patients, five relatives and 63 staff. Staff included junior and senior registered nurses, health care assistants, housekeeping staff, student nurses, discharge co-ordinators, allied health professionals such as physiotherapists and junior and senior medical staff.

We observed interactions between staff, patients, and patient's relatives, considered the environment, looked at 12 sets of medical and nursing care records, and reviewed 23 patient observation / sepsis screening pathways. Before our inspection, we reviewed performance information from, and about, the trust.

Medical care (including older people's care)

Summary of findings

We rated medical care services as inadequate overall.

We rated safe, caring and well led as inadequate and effective and responsive as requires improvement because:

- The approach to reviewing and investigating incidents was insufficient and too slow and led to unacceptable delays.
- We were not assured incidents were reported appropriately, investigated, that lessons were learnt and shared in a timely way.
- Where patients had met the criteria for treatment of sepsis, staff were not always responding appropriately in administering treatment in the recommended time frame and in line with the "sepsis six" care bundle.
- We were not assured patients were receiving their medication as prescribed. Twenty seven out of 36 medication record charts showed there had been omitted doses of medication with no reasons recorded. Eleven of these omitted medicines were critical medicines such as anticoagulants, antibiotics and anti-epileptic medicines.
- Out of the 36 medicine administration records, we found two where medication administration errors had occurred. Niether of these had been reported as incidents.
- Staff were not adhering to the trust policy for adult tracheostomy management (November 2016) guidelines which put patients at risk of avoidable harm. Checklists for the safe delivery of care for patients with a tracheostomy were not available at the patient's bedside.
- Staff caring for patients with a tracheostomy were not competent to do so but this had not been raised as a risk to patient safety.
- Cleanliness and hygiene was not given sufficient priority. The kitchen on ward 6A was in a state of disrepair. This meant there was an increased risk of cross contamination because staff could not clean these surfaces effectively.
- Individual care records in some areas were not always written and managed in a way that kept people safe. Some records were incomplete and not up-dated to reflect patients care needs.
- Fluid balance charts were not always updated appropriately to minimise risks to patients
- At the time of our inspection systems, processes and practices that are essential to keep patients with a mental health condition safe had not been identified. There were no ligature risk assessments or ligature cutters available on the acute medical unit which meant risks to patients was not minimised.
- We did not see records to assure us that refrigerated medicines were stored at the correct temperatures and temperature recording was not in line with the trust's policy. Limited shelf life products did not display a date of opening or a new expiry date. We were therefore not assured these medicines remained safe and effective to use.
- Staff training compliance for safeguarding adults and children did not meet the trusts mandatory target of 95% completion.
- None of the staff groups met the trust target of 95% for a majority of their mandatory training.
- Nurse staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times. The trust was not adhering to national guidelines in respect of the number of staff required to care for patients requiring non-invasive ventilation (NIV) due to low staff numbers and increased use of agency and bank nurses.
- Medical staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times.
- Two out of eight relatives we spoke with were unhappy with the care their relative received. These related to delayed diagnosis, not able to reach drinks or the call bell, lack of communication and poor hand hygiene. We received information from relatives and or carers of patients after our inspection stating perceptions that patients were not being cared for in a kind and respectful manner.

Medical care (including older people's care)

- On wards 6A and 6B we observed instances where staff had not taken steps to maintain a patient's privacy and dignity.
- On Ward 6A we observed one instance where a patient was distressed about the care being delivered to them but nursing staff did not speak to the patient, stop what they were doing or attempt to reassure the patient in any way.
- On ward 6A, we observed treatment being delivered which did not show any repect for the patient or for the effect the treatment might have on them.
- On ward 6A, staff did not always ensure patients had call bells and we observed delays in call bells bein answered on wards 6A and 6B.
- We observed patients basic needs were not met. Patients were not always treated with privacy and dignity.
- 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.
- Staff raised concerns related to one computerised tomography (CT) scanner (introduced in 2009) available for patients. This scanner was periodically out of use due to predicted servicing and it breaking down . Medical staff told us the length of time taken to transfer patients to Lincoln County hospital decreased the best time for treatment for patients with a hyper acute stroke who required thrombolysis.
- Systems were not robust to identify vulnerable patient groups which included patients living with dementia and patients with learning disabilities.
- Staff were not clear of the direction the service was heading despite the trust having a clear vision and strategy for medicine.
- Leaders within the service had failed to identify and act on issues about risk and patient safety within medicine.
- There were risks we we identified that posed a risk to safe care and treatment of patients that had not been recognised. These included no availability of a gastrointestinal bleed rota, not all staff were trained as competent to deliver care to patients receiving non-invasive ventilation and tracheostomy care, sepsis six treatment targets were not being met, mandatory and safeguarding training was below trust target, ligature risk assessments.
- Poor standards of care had become normalised by some staff members in some clinical areas.
- We were not assured there was sufficient professional challenge given to the nursing staff. This meant some staff lacked the capability to recognise what good care looked like.
- We were not assured leaders within the hospital had oversight of the clinical care being delivered on the wards.
- We were not assured local leaders had the necessary knowledge and capability to lead effectively.
- Leaders were out of touch with the clinical care being delivered on the front line. The local leadership team had failed to identify risks to patient safety and that patients basic needs were not always being met and there was a lack of clarity about how staff were held to account.
- Cross-site working was inconsistent across medicine at Pilgrim hospital.
- We received mixed feedback from staff about morale and feeling they could rasie concerns and were listened to.

However:

- Stroke medicine provided timely access to initial assessment, diagnosis or urgent treatment of those patients who may be experiencing a stroke. For 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, Pilgrim hospital scored level A for seven out of 14 of the indicators on a scale where level E is the worst possible.
- Clinical nurse specialists were available for advice and support in a number of specialties including

Medical care (including older people's care)

stroke services, cancer services and for care of the older person. A dementia practitioner was available to talk with and support patients and their carers who were living with dementia.
- The hospital participated in the national safety thermometer scheme. Safety information was publicly displayed in all ward areas we visited.
- 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.

Are medical care services safe?

Inadequate

We rated safe as inadequate because:

- The approach to reviewing and investigating incidents was insufficient and too slow and led to unacceptable delays.
- We were not assured incidents were reported appropriately, investigated, that lessons were learnt and shared in a timely way.
- Where patients had met the criteria for treatment of sepsis, staff were not always responding appropriately in administering treatment in the recommended time frame and in line with the "sepsis six" care bundle.
- We were not assured patients were receiving their medication as prescribed. Twenty seven out of 36 medication record charts showed there had been omitted doses of medication with no reasons recorded. Eleven of these omitted medicines were critical medicines such as anticoagulants, antibiotics and anti-epileptic medicines.
- Out of the 36 medicine administration records, we found two where medication administration errors had occurred. Neither of these had been reported as incidents.
- Staff were not adhering to the trust policy for adult tracheostomy management (November 2016) guidelines which put patients at risk of avoidable harm. Checklists for the safe delivery of care for patients with a tracheostomy were not available at the patient's bedside.
- Staff caring for patients with a tracheostomy were not competent to do so but this had not been raised as a risk to patient safety.
- Cleanliness and hygiene was not given sufficient priority. The kitchen on ward 6A was in a state of disrepair. This meant there was an increased risk of cross contamination because staff could not clean these surfaces effectively.

Medical care (including older people's care)

- Individual care records in some areas were not always written and managed in a way that kept people safe. Some records were incomplete and not up-dated to reflect patients care needs.
- Fluid balance charts were not always updated appropriately to minimise risks to patients
- At the time of our inspection systems, processes and practices that are essential to keep patients with a mental health condition safe had not been identified. There were no ligature risk assessments or ligature cutters available on the acute medical unit which meant risks to patients was not minimised.
- We did not see records to assure us that refrigerated medicines were stored at the correct temperatures and temperature recording was not in line with the trust's policy. Limited shelf life products did not display a date of opening or a new expiry date. We were therefore not assured these medicines remained safe and effective to use.
- Staff training compliance for safeguarding adults and children did not meet the trusts mandatory target of 95% completion. We were therefore not assured all staff would be able to respond appropriately.
- None of the staff groups met the trust target of 95% for a majority of their mandatory training.
- Nurse staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times. The trust was not adhering to national guidelines in respect of the number of staff required to care for patients requiring non-invasive ventilation (NIV) due to low staff numbers and increased use of agency and bank nurses.
- Medical staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times.

However, we also found:

- The hospital participated in the national safety thermometer scheme. Safety information was publicly displayed in all ward areas we visited. This meant patients and the public could see how the ward was performing in relation to patient safety.
- A central equipment store was available on this hospital site. The equipment store responded to ward requests for equipment 24hours a day.
- For endoscopic procedures, the service took into account the British Society of Gastroenterology (BSG) Quality and Safety Indicators for Endoscopy.

Incidents

- A risk management reporting policy due for review 24 October 2016 included the trust's incident grading system as well as external and internal reporting requirements which was available to staff. Incidents, accidents and near misses were reported through the trust's electronic reporting system.
- All staff we spoke with told us they were familiar with the process for reporting incidents, accidents and near misses using the trust's electronic reporting system.
- Staff told us they received feedback from incidents through ward meetings, email and during handovers. We saw evidence of this documented in ward meeting minutes. However, staff told us they did not always receive feedback from incidents related to low staffing numbers and therefore did not always report this due to the lack of feedback.
- We also saw evidence of a backlog of investigated incidents to be considered for discussion at the care of the elderly governance meeting on 19 September 2016. The evidence documented fifty-one incidents reported before July 2016 were still to be investigated and closed. Of the 51 incidents, 37 were related to ward 6B, nine were related to ward 6A, three were regarding the acute medical unit (AMU), one on ward 7B and one was classified as 'other'. There were also 38 closed incidents related to patient falls, which demonstrated no evidence of review, investigation or learning. Out of the 38 incidents 14 happened between 9pm and 7am. Following the inspection, we requested and received the care of the elderly clinical governance meeting minutes for 19 September 2016, which demonstrated the backlog of investigated incidents had not been discussed, therefore, we were not assured incidents were being investigated, reviewed or that lessons were being learnt and shared to maintain patient safety.
- During our inspection, we saw a patient with a tracheostomy who required expert care. The patient had been admitted to a ward where staff did not have the required clinical skills to provide safe tracheostomy care. Staff did not report this as an incident. A

tracheostomy is an artificial opening of the windpipe for the relief of breathing difficulties. We were therefore not assured that staff reported all incidents appropriately within medicine.

- During our unannounced visit, we found two drug administration errors on the drug recording chart, one on ward 6A and one on ward 6B. We spoke with a trained member of staff on each of the wards who told us they would record the errors as an incident. Following our inspection, we requested the incident notification reference for these errors. Information provided by the trust demonstrated that the incident on ward 6A had been raised, however, the incident on ward 6B had not. We could therefore not be assured all incidents were being raised and recorded in line with trust policy.
- Medical services at this hospital reported 2138 incidents between July 2015 and June 2016. Of these, 10 resulted in death, 30 resulted in severe harm, 246 in moderate harm, 286 in low harm and the majority, 1566 in no harm or injury.
- The most frequently reported incident categories were 555 reports for slips, trips and falls, 221 related to medication, 167 reported as lack of suitably trained staff, and pressure ulcers, which resulted in 127 reports.
- The trust reported 30 serious incidents between July 2015 and June 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant they warrant using additional resources to mount a comprehensive response. Of these 15 were related to pressure damage to the skin, eight were slips, trips or falls and three were related to diagnosis failed or delayed.
- We reviewed three serious incidents which had originally been reported through the electronic reporting system, ten, five and four months ago; information provided by the trust indicated two were being run as serious learning events and were still incomplete and one was waiting executive approval. This meant that investigation reports were still outstanding. We could not be assured incidents were being investigated, lessons learned or actions identified in a timely manner.
- Between August 2015 and July 2016, the trust reported no never events for medical care. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Mortality and morbidity meetings were held monthly across all medical specialties to discuss patient deaths. Mortality and morbidity meetings give health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. The trust's mortality review assurance group (MoRAG) further reviewed 10% of all mortality and morbidity reviews. Minutes from the meetings (April 2016, May 2016 and June 2016) showed mortality reviews had taken place with evidence of shared learning and where applicable any actions required to be taken forward.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff we spoke with demonstrated and understanding of the duty of candour and gave examples where this had been applied which included when a patient had fallen and sustained an injury, the family were informed and a meeting was arranged to follow up any concerns.

Safety thermometer

- The hospital participated in the national safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas for example, falls with harms, catheter associated urinary tract infections, pressure damage and venous thromboembolism (VTE). VTE is the formation of blood clots in a vein.
- Trust wide data for medicine from the patient safety thermometer showed there were 57 pressure ulcers, 62 falls with harm and 13 catheter urinary tract infections between October 2015 and October 2016.
- Data for eight medical wards for May 2016 and June 2016 showed a harm free care rate of between 93% and 100%. For May 2016 and June 2016 the majority of wards performed similar to or better than the hospital average (94%) and two wards performed worse than the hospital average with harm free care reported as being around 93%. These wards were 6A and 6B.

- Safety information was displayed in all ward areas we visited. This meant patients and the public could see how the ward was performing in relation to patient safety.
- On ward 6A and 6B we were told patients assessed as being a high risk of falling were located in the same nursing bay where a member of staff would remain all of the time. The ward manager implemented this to reduce the incidents of preventable falls. Information provided by the trust demonstrated a reduction in falls, which resulted in harm (35) in 2014, compared with 25 in 2016.

• Cleanliness, infection control and hygiene

- Trust wide there had been 60 cases of clostridium difficile (c. difficile) infections between July 2015 and June 2016. C. difficile is an infective bacterium that causes diarrhoea, and can make patients very ill.
- Meticillin resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between July 2015 and June 2016, there were no cases of MRSA reported at this trust.
- Meticillin sensitive Staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between July 2015 and June 2016 there were 35 recorded cases of MSSA trust wide. The trust were unable to separate the data into the exact numbers for this core service.
- In order to measure compliance with trust policies, the Infection Prevention Team (IPT) carried out regular audits against key policies. For example, hand hygiene and the availability and appropriate use of personal protective equipment (PPE).
- The Trust' hand hygiene results World Health Organisation's (WHO) "5 moments for Hand Hygiene" reflect observed compliance prior to individual challenge to reflect more accurate practice. Between January 2016 to June 2016 (six months) for the eight clinical areas, compliance rates of between 98% and 100% were reported with the exception of one submission of 50% for February 2016 on ward 6A and one submission of 88% compliance for June 2016 on the acute medical assessment unit (AMU). However, there were clinical areas with results 'not recorded', these included ward 8A for the whole reporting period, AMU for three out of the six months, acute cardiac unit with five out of six months, and ward 6B and ward 9A with one 'not recorded' out of the six months. Following our inspection the trust told us In July 2016, a revised reporting process for the hand hygiene audit had been implemented to address the issue of incorrect data submission being counted as a nil return in reports.
- Throughout the medical wards we inspected, staff were compliant with best practice regarding hand hygiene. There was access to hand washing facilities and a supply of personal protective equipment (PPE) which included gloves and aprons. We observed staff wash their hands or use hand sanitising gel between contact with patients.
- We observed staff to be 'bare below the elbows' (BBE) in line with trust policy.
- We saw barrier nursing was carried out where required. Barrier nursing is a method of nursing patients while preventing the transmission of highly contagious diseases. A patient can be isolated to prevent the spread of disease to others, or isolation is imposed to protect a patient with a compromised immune system.
- Care and treatment was not always provided in a way which minimised the risk of avoidable harm to patients. Staff did not always assess the risk of and prevent, detect and control the spread of infections. For example, on ward 6B we saw an intravenous administration set suspended from a stand with an open connection which had previously been secured to a patient. On the same ward we saw a member of staff answer a telephone wearing gloves whilst in the process of handling dirty linen. The floor in a patient room was visibly dirty with dried fluid stains under the bed. We also observed a blood stained tracheostomy bib in an open box, which also contained sterile tubes for suctioning secretions from a tracheostomy. We raised our concerns with the nurse allocated to this area who told us she would take immediate action. On our return the issues had been dealt with.
- We found the kitchen area on ward 6A was in need of refurbishment. The worktops and cupboard doors and shelves were cracked and damaged. This meant there was an increased risk of cross contamination because staff could not clean these surfaces effectively. There was a lack of cupboard space, and we found nutritional supplements and boxes of cereals were stored on open shelves. There was dirt and debris on the floor in the kitchen area and there was dust down the side of the refrigerator. There was no cleaning rota so we could not establish when the floor had last been cleaned. Bread was being stored in a bread bin, which had started to

rust. In the refrigerator, we found patients yoghurts had gone past their expiry date and two plates of sandwiches did not display an expiry date. We were therefore not assured the sandwiches were within their expiry date. We raised our concerns with the nurse in charge who told us the state of the kitchen had been escalated and had been added to the service's risk register. We reviewed the risk register and noted the kitchen had been on the risk register since February 2013 and had last been reviewed in March 2015. We raised this with the Head of Nursing who told us another issue on ward 6A had been assessed and dealt with as a priority. The replacement of the kitchen was the next priority once funding was available.

- On ward 6A, we found specialist nutritional fluids used for enteral feeding were not stored in a way that protected patients from the risk of getting health care associated infections such as gastroenteritis. Enteral feeding is a type of feeding used for people who cannot eat normally. Liquid food is given through a tube directly into the gut. On ward 6A, enteral feed was stored in the kitchen. We found a box of enteral feed stored on the kitchen floor and a further two boxes of enteral feed were stored on a worktop. One of the boxes also contained two pairs of domestic rubber gloves and plastic cups. Beside the boxes were a dish and a plate, which contained the remains of food and there was also a damp towel. We were therefore not assured staff took sufficient precaution to protect patients who required enteral feeding from healthcare acquired infections. We escalated our concerns to the nurse in charge who assured us they would take action to remove the feed. When we returned to the ward, we saw appropriate action had been taken to remove and appropriately store the feed.
- On ward 6A we saw a housekeeper loading food onto the food warmer did not wear personal protective equipment (PPE) whilst undertaking this task. We asked the housekeeper about the use of PPE and they told us they had never been advised to wear it. The housekeeper told us they had not received food hygiene training since being employed at the hospital. We requested information relating to ward service hygiene and serving meals training for the medical wards at Pilgrim hospital. Data provided demonstrated no members of staff were trained for 2015 or 2016. The last recorded training for ward 6A was for three members of staff for July 2014.
- We saw equipment was visibly clean and identified as clean and ready for use with the 'I am clean' stickers dated and signed appropriately.
- We saw cleaning checklists for commodes, which staff had signed and completed appropriately.
- All staff on the oncology ward (7A) were trained to manage chemotherapy spillages. Chemotherapy spillage kits were located on the ward and staff demonstrated an understanding of where these were and how to use them.
- Hand wipes were available on meal trays to allow patients the choice to clean their hands prior to eating.
- We observed a naso gastric feeding tube being flushed with a syringe which had already been used. The syringes used to flush the tubes should be single use.
- Equipment that had been used for endoscopy procedures was cleaned and sterilised on site. The decontamination of scopes complied with the Health Technical Memorandum 01-06: Decontamination of flexible endoscopes.
- Results received for environmental cleaning audits between January 2016 to April 2016 ranged between 78% and 100% compliance. The majority of areas were below the trust target of 95%. The areas below 80% were ward 6A (79% in January 2016 and April 2016), cardiology ward (78% in April 2016), ward 7B (79% in February 2016) and ward 9A (79% in April 2016).

Environment and equipment

- At the time of our inspection systems, processes and practices essential to keep patients with a mental health condition safe had not been identified. In January 2015, the Department of Health issued an alert to NHS trusts requiring action to reduce the risk of strangulation in children and vulnerable adults from loop cords and chains on window blinds. Whilst we did not see the use of loop cords and chains within the acute medical unit (AMU) we did see a number of potential ligature points such as door handles hooks used to hang frames around toilets. The CQC defines a ligature point as anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Staff showed a limited knowledge of what formed a ligature risk, had no knowledge of what ligature cutters were (ligature cutters are specially designed to offer an effective and safe method of cutting a ligature attached to a person) and had not risk

assessed the environment in AMU to identify ligature points and minimise risks to patients. We raised this with the head of nursing who told us our concerns would be addressed.

- During our unannounced inspection, there were no ligature cutters available, staff did not know if these had been ordered. Staff said the ligature risk assessments were currently under review.
- We formally wrote to the trust notifying them of our concerns in order that a response could be provided by the trust 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. We saw actions were specific, measurable, achievable, realistic and timely (SMART).
- We checked the resuscitation equipment on six ward areas. Most of the single-use items were sealed and in date, and emergency equipment had been serviced with the exception of a missing security seal on the trolley on ward 8A and an out of date (expired June 2016) tracheal intubation stylet (a metal wire used to guide the breathing tube when inserting into the wind pipe) on ward 7B. We raised this with the nurse in charge who replaced the equipment immediately. Resuscitation equipment had been signed by staff as being checked daily to indicate it was safe and ready for use in an emergency.
- A central equipment store was available on this hospital site. The equipment store responded to ward requests for equipment 24hours a day. The equipment store was responsible for checking and servicing equipment to ensure it was ready for patient use. None of the staff we spoke with raised concerns regarding provision and access of equipment.
- We reviewed 40 items of patient-care equipment. Most patient-care equipment had been routinely checked for safety with visible safety tested stickers demonstrating when the equipment was next due for service. However, on ward 8A we observed a set of weighing scales had expired from having their next service. This meant we could not be assured this equipment had been safety checked or that it was safe to use. We raised this with the nurse in charge who took immediate action to remove this piece of equipment from use.
- Staff on ward 8A (gastroenterology ward) raised concerns about patients who presented with challenging behaviour and aggression. The ward was located on the eighth floor and accessed by the main public lifts or stairs. Ward 8A was the only ward open on this level as ward 8B had been closed. Visitors entered the ward through a controlled access system fitted to the double doors, which staff on the ward controlled. In the event of a security or safety issue there was a security officer and a site manager available 24 hours a day, but staff told us the response times were dependant on the demand of work at the time a call for assistance was made. Following our inspection we requested the risk assessment for this ward. The trust provided the security management risk assessment (review 2014) which assessed the overall risk rating of this ward as medium to high. Evidence provided by the trust demonstrated three incidents relating to patient aggression between October 2015 and June 2016.
- We were told that the call bell system on ward 6A was currently being refurbished. Reading lights above patients bed spaces did not work, this meant if a patient needed assistance or was unwell in the night the staff had to turn the full ward lights on which disturbed other patients. We were told this had been the case for the past 4 months.

Medicines

- A pharmacist and pharmacy technicians visited wards each weekday and provided on-call support out of hours. Pharmacy staff checked patients medicines on admission to ensure they were correct and that records were up to date. Medicines interventions by a pharmacist were recorded on the paper charts to help guide staff in the safe administration of medicines. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.
- We looked at the medicine administration records for 36 patients across four wards, which included ward 6A, 6B, 7B and the acute medical unit (AMU). We identified 27 of these records showed doses of medication had been omitted with no reasons for this recorded. Elven of these omissions were critical medicines such as anticoagulants, antibiotics and anti-epileptic medicines. Following our inspection the trust told us audits of medications administered as prescribed on time monthly with an average compliance of 90% for Pilgrim between July and December 2016.
- Allergies were recorded on charts and patients with an allergy wore red wristbands as a further measure to

minimise the risk of allergic medicines being administered. Where antibiotics were prescribed, indications and durations of treatment were recorded appropriately.

- Out of the 36 medicine administration records, we found two where medication administration errors had occurred. These included the administration of an incorrect dose of strong pain relief medicine and the administration of a blood thinning medication, which had been administered from a chart without patient identifiable information being documented. We spoke with the nurse in charge concerned who told us they would raise these as incidents and address our concerns.
- We spoke with eight patients who all told us they received information about their medicines whilst on the wards although three expressed concerns about the timings of medicines.
- Medicines, including intravenous fluids were stored securely and we saw controlled drugs (CDs) were stored and managed appropriately. CDs require extra controls and should be stored in an approved locked cupboard which can only be opened by a person who can lawfully be in possession of them, such as a pharmacist or nurse in charge.
- Wards were not consistently recording maximum and minimum fridge temperatures daily therefore, it was not clear medicines were stored at the correct temperatures to ensure they would be fit for use. The method of temperature recording was not in line with the trust's policy. Limited shelf life products did not display a date of opening or a new expiry date, meaning that staff could not be assured these medicines remained safe and effective to use.
- Staff described accessing the correct medicines for discharge as a problem although the use of over labelled pre-packs had improved the situation. Problems arose when there were discrepancies between the medicines chart and the expected date of discharge (EDD), resulting in the medicines produced for discharge by pharmacy (from the medicines administration chart) being incorrect and these situations took significant time to resolve.
- During medication administration rounds nurses wore red tabards stating 'drug round in progress, do not disturb'. This visually identified the nurse to staff and visitors limiting the possibility of being disturbed and allowing the staff member to carry out the administration round as efficiently as possible.

Records

- During our inspection, we reviewed 12 medical and nursing care records and 23 patient observation/sepsis screening pathways.
- Medical and nursing care records were paper-based and held at the patient's bedside and, in notes trolleys in the main ward corridors. The majority of the notes trolleys were not secure. For example, on the AMU we were able to access patient notes from a notes trolley, situated in a corridor, unattended. This meant there was a risk of access to a patient's medical notes by an unauthorised person. When we went back on our unannounced visit, staff had moved the trolley to an area allowing visibility at all times
- Staff used an electronic hand held system to record patient's physiological observations. Patient observations were displayed on a central monitor at the nurses' station. This was an interactive white board, which allowed oversight of all of the patients on the ward. It also alerted staff to the time the next observations were due, for example, amber colour indicated two hours until the observation was next due and red signified they were overdue.
- Records were mostly legible, accurately completed and up to date.
- Staff used nursing care records throughout all medical wards at this hospital. Care plans were pre-printed, which were not always individualised to the patient's care requirements. Care plans included pain, communication, nutrition and hydration, mobility and personal care and hygiene.
- We saw care records were not always completed or updated appropriately. For example, on ward 6A a care plan had not been updated for 11 days and another had not been up-dated for five days. On the same ward, two charts to record hourly intentional rounding were incomplete, the nutrition assessment scores had not been updated on two patients for five and six days respectively and a fluid balance chart was incomplete. On ward 6B, three charts to record hourly intentional rounding were incomplete and we found a patient's fluid balance chart had not been up-dated hourly as requested by the doctor. This patient had been

admitted with severe dehydration, which had caused acute kidney injury (AKI). AKI is sudden damage to the kidneys that causes them not to work properly. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs. The Trust audited care planning monthly through the Safety and Quality Audits which report. For October 2016, the SQD which is based on a sample size of 68 for medicine services reported 95.1% compliance for a pressure prevention care plan in place, 100% of nutritional care plans in place for appropriate patients, 76.3% for a urinary catheter care plan in place, 91.9% for a falls prevention care plan

- Patient records were multidisciplinary and we saw that nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech and language therapists and dietetics staff had made entries.

Safeguarding

- The trust had a safeguarding adults policy (review 2019) and a safeguarding children and young people policy (review September 2016).
- The trust had a safeguarding lead at executive level in addition to local named leads for children and adult safeguarding. All staff we spoke with were aware of the safeguarding leads and none reported any issues accessing the safeguarding leads for support or advice.
- As of 31 August 2016 training compliance for medical and non-medical staff for safeguarding adults levels one to three was 61% and 80% respectively and, safeguarding children was 65% and 80% respectively. This did not meet the trust mandatory target of 95% completion for safeguarding training. There are a total of five levels of training. Level 1 applies to all staff including non-clinical managers and staff working in healthcare settings. Level 2 is the minimum level required for non-clinical and clinical staff that has some degree of contact with children and young people and/or parents/carers. Level three is for clinical staff working with children, young people who contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Throughout medical services most of the staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. However, a patient on ward 6B had been admitted from a care facility in the community suffering with kidney failure related to dehydration. We spoke with the ward manager who was not sure whether a safeguarding referral had been made but would raise one if not. We went to ward 6B that evening and spoke with a member of staff as to whether a safeguarding referral had been made they were unsure. We raised this as a separate safeguarding referral as part of our CQC processes to alert the local authority of our concerns. Following our visit we requested further information from the trust related to the submission of a safeguarding referral from ward 6B. Following our inspection we found evidence that a safeguarding referral had not been made therefore we were not assured staff were following trust safeguarding policies and procedures.
- A framework for mandatory reporting was in place to safeguard women or children with, or at risk of, female genital mutilation (FGM). Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.
- There were safeguarding link nurses identified on the ward areas who were able to up-date and support staff with regard to safeguarding processes and information.

Mandatory training

- Mandatory training for all staff groups included; fire safety training, moving and handling, infection control, equality, diversity and human rights, information governance, safeguarding children (level one to three), risk awareness, safeguarding adults (level one to three), health and safety, basic life support and slips, trips and falls.
- Training compliance at the time of the inspection demonstrated no staff group within the service met the trust target of 95% for their core learning; although it is noted that compliance for BLS improved from 29% in August 2016 to 48% in October 2016 for medical staff and 49% to 60% for nursing. Likewise, improved compliance was noted for Fire Safety Training from 58% to 68% for doctors and 69% to 78% for nursing during the same time period.

Assessing and responding to patient risk

- Data received from the trust demonstrated that between October 2015 and September 2016, between

84.6% and 100% of patients were assessed by a suitably qualified medical practitioner within 30 minutes of admission and reviewed by a relevant medical consultant within 12 hours. This was mostly in line with the London Quality Standards.

- Staff used the National Early Warning Score (NEWS), to record routine physiological observations including blood pressure, temperature, respiratory rate, oxygen saturation levels and heart rate. The recording generates a score, which acts as a trigger for further interventions from increased frequency of observations to urgent medical intervention. Patients with suspected infection, a NEWS of five or more or for whom staff or relatives expressed concern should to be screened for sepsis. Sepsis is a severe life-threatening infection, which occurs when the body's response to an infection results in damage to the body's tissues and organs.
- Trust guidelines were for all patients with suspected sepsis to receive treatment in line with the 'sepsis six bundle', this means patients receive immediate interventions to increase their survival from sepsis. Research has found significant mortality reductions when treatment such as antibiotic therapy is started within one hour.
- We asked the trust to provide us with sepsis audit data for March 2016 to September 2016. The trust provided data for medical services for May 2016 to September 2016. The data captured information relating to the sepsis bundle, NEWS, whether sepsis bundle actions were undertaken within an hour and whether antibiotics were administered within an hour. The data showed this information had not been collected for all wards within this timeframe; data was incomplete for all eight clinical areas. For example, within this timeframe, there were 26 out of 40 occasions where data had not been collected for patients who did not receive their antibiotics within one hour. We were therefore not assured the trust had a robust system in place for assessing the effectiveness of sepsis identification and treatment throughout the medical wards.
- During our inspection, we reviewed 23 patient NEWS charts across five wards. We found incomplete recordings of observations for monitoring, and three patients out of 23 who did not receive treatment in line with a sepsis six trigger within the first hour. We therefore found inconsistencies in the treatment of sepsis, this meant patients were at risk of not receiving treatment for sepsis in the recommended time.
- 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 to be taken.
- During our inspection, we met with the associate medical director for the trust to discuss plans to improve sepsis management. There were plans in place to improve performance across wards throughout the trust. This included the roll out of sepsis boxes in all clinical areas and the introduction of a patient group direction (PGD) for an injectable antibiotic. Staff we spoke with told us they had heard of the sepsis boxes but had not yet seen them on the ward areas. A PGD is a set of instructions, which detail the conditions under which a prescription medicine can be supplied to patients without a prescription. A business case had also been made to recruit two full-time sepsis nurses, one of which would be based at this hospital. There was also a plan for the roll-out of an electronic learning package. The associate medical director told us they were confident there would be an improvement in sepsis management and treatment within six months of our inspection.
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance for Gastrointestinal Haemorrhage: Time to Get Control (2015) states there must be a gastrointestinal bleeding (GI) rota to provide treatment anytime of the day or night, either on-site or as part of an agreement within a network of providers. 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. Guidelines were available (review December 2016) for the management of patients with upper gastro-intestinal bleeding however, staff did not demonstrate a consistent awareness of this. The guideline stated there would be out of hours review by a consultant, however, not all consultants were trained in the management of this condition, which meant patients could be at increased risk of harm
- 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 a plan outlining actions they were going to take to address our concerns. The action plan did not set out clear steps as to how they were going to manage this risk 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 this included a transfer protocol agreed between physicians on all sites. In addition, there were plans to audit the outcomes of patients with a GI bleed. Plans to provide a GI bleed rota for February 2017 were still on going.

- There was a dedicated bed on the oncology ward for patients with neutropenic sepsis. There was a neutropenic sepsis pathway for staff to follow with direct patient access to the ward for assessment and treatment if required. Neutropenic sepsis is caused by a condition known as neutropenia, in which the number of white blood cells in the blood is low.
- Ward 7B was the designated ward for patients who had a tracheostomy. During our inspection, we saw a patient on ward 6B who had a tracheostomy who required expert care. The patient had been admitted to a ward for two days where staff did not have the required clinical skills to provide safe tracheostomy care. This meant there was a risk of harm to this patient. We raised our concerns with the ward manager and the Chief Nurse who told us they would arrange for the patient to be transferred to ward 7B. We were concerned this had not been identified as a risk at the time the patient was admitted to the hospital. We returned later the same day to find the patient had been transferred to ward 7B.
- There was a policy in place for adult tracheostomy management (review November 2016). The policy identified documentation required to be in place at the patient's bedside, which included a tracheostomy care chart, an essential equipment checklist and a bed head sign that included information of tracheostomy tube size, emergency contacts and type of tracheostomy device. During our inspection, we saw two patients with a tracheostomy who required expert care admitted to ward 7B. On review of the patients' documentation, we saw no evidence of an essential equipment list or signage at the bed head of the patient. However, we did see evidence of a tracheostomy care checklist. We raised our concerns with the nurse in charge who told us they would take action to ensure the necessary safety requirements were put in place. When we returned to the hospital on 22 December 2016, we found evidence that staff had received training on the care of tracheostomy care and treatment.
- Fluid balance charts were in use to monitor a patient's fluid intake and output. We reviewed 23 patients requiring fluid balance charts. Of these, two were not up to date and accurately calculated on the acute medical unit (AMU) and ward 6B.
- We observed one instance on ward 6B during our announced inspection where a patient had a very dry and cracked mouth but there were no records to indicate they had been given any mouth care. We raised this with the nurse caring for the patient who addressed this.
- For endoscopic procedures, the service takes into account the British Society of Gastroenterology (BSG) Quality and Safety Indicators for Endoscopy.
- The trust was piloting an enhanced care bundle. This was aimed at patients who, without supervised observation, may be at an increased risk of falls, harm or isolation. At Pilgrim hospital, this was being piloted on wards 6B and 3A. On ward 6B we saw that a group of patients who met this criteria had been cohorted in one bay. There was a member of staff in the bay at all times to attend to the needs of these patients. If the member of staff needed to leave the bay, another member of staff took over. The aim was to ensure these high-risk patients were supervised at all times.

Nursing staffing

- There were tools in place to collect patient acuity and dependency data. Acuity means the level of seriousness of the condition of a patient. The patient acuity and dependency scores were collected daily and matrons and the senior nursing teams confirmed this data on morning board rounds and unannounced visits to clinical areas. The data was considered alongside staffing information from the electronic rostering system and patient information including admissions and discharges undertaken in different clinical areas.
- Planned and actual staffing levels were displayed in all the wards we inspected and information displayed indicated actual staffing levels mostly met planned staffing levels. Where there were 'gaps' in staffing bank and agency staff had been requested.
- During our inspection, we found staffing levels in most areas were sufficient to deliver safe patient care.

However, nursing staff on Wards 8A, 7B and 6B raised concerns about the high use of agency nurses. We saw from ward staffing rotas and trust wide vacancy data that there were vacancies within these areas of 5.86 whole time equivalent (wte), 10.8 wte and 7.02 wte respectively. Ward managers told us the use of agency and bank nursing staff helped to manage staffing shortfalls. Senior leads raised staffing vacancies as a concern within medicine, which was identified on their risk register.

- As of June 2016, Pilgrim hospital reported a vacancy rate of 20% in medical care; based on 67.07 whole time equivalent vacancies.
- Data for June 2016 demonstrated planned nursing staffing levels across the eight clinical areas totalled 302.97 whole time equivalents (wte) with actual staffing levels as 239.96 wte. The three areas with the highest vacancy rates were; the acute medical unit (AMU) (16.8 wte), ward 7B (10.8 wte) and ward 9A (10.2 wte). On the acute medical unit (AMU) staff told us recruitment had improved with an increase to the nursing template which was being maintained. Not all staff were re-assured about this.
- The respiratory ward (ward 7B) could accommodate two patients requiring non-invasive ventilation (NIV). NIV is a form of breathing support without using equipment that goes into the body. However, the trust was not adhering to national guidelines in respect of the number of staff required to care for patients requiring NIV. British Thoracic Society 2008 Guidelines state there should be a minimum staffing ratio of one nurse to two patients for at least the first 24 hours of NIV. At the time of our inspection, staff told us, one nurse would be allocated to patients requiring NIV but would also be expected to provide care and support for an additional four patients. We did not establish if this was for all patients receiving NIV or patients within the first 24 hours of NIV.
- We wrote to the trust notifying them of our concerns about the care of patients requiring NIV in order that a response could be provided by the trust detailing how they were going to address our concerns to minimise risk to patients. In response, the trust provided a detailed plan outlining actions they were taking to address our concerns. Information included evidence of staffing analysis, evidence of escalation to the trust board and evidence of the acuity of patients and an audit of staffing. We were not assured that all staff had appropriate competencies to care for patients receiving NIV.
- There was one whole time equivalent venous thromboembolism (VTE) nurse trust wide. When this nurse took annual leave, there was no one to cover for them.
- The average nursing bank and agency usage rate for April 2015 to March 2016 across medicine was 25.6%. Agency staffing was managed on a day-to-day basis with agency use 'shared out' across the wards to mitigate the risk of high numbers of agency staff in any one ward area at any one time.
- An operational matron had oversite of all of the medical wards and visited each ward daily to assess the level of staffing and to support staff.
- We attended an afternoon nurse handover from the early shift to the late shift on ward 6A. The staff handed over appropriate information to the incoming staff discretely and in private.
- Agency and bank staff received a local induction checklist to the ward area, which included the location of emergency equipment, ward orientation and working procedures. The nurse in charge signed this with the temporary staff member to confirm completion.
- The Trust were in the process of producing an agency/ bank engagement and development packaged called 'Key to Care' which aimed to up skill and develop temporary staff thus improving quality of care provided and patient safety. It is also anticipated to encourage recruitment to permanent positions. Staff we spoke with were not aware of this document.
- We spoke to 16 members of staff who raised concerns about the impact of staffing shortages. One nurse told us they felt concerned about patient safety, particularly at night because of the high numbers of agency nurses being used because agency nurses did not necessarily have the competencies to care for the patients they were being asked to look after.

Medical staffing

- The proportion of consultants and junior doctors reported to be working at the trust on the medical wards was higher than England average.
- A consultant reviewed patients daily on the acute medical unit (AMU). Patients were seen by a senior doctor after 6pm and then reviewed by the consultant

the following morning. Once transferred to a general ward, a consultant reviewed patients during a consultant-delivered ward round at least once every 24 hours Monday to Friday.

- At weekends, two consultants provided cover on-site. One consultant would cover the AMU providing two daily ward rounds and provided cover 24 hours per day. The other consultant would provide cover for the medical wards for four hours each day to review sick and unwell patients and to facilitate discharges.
- The AMU had three consultants. There was on-site consultant cover on the AMU from 8am until 6pm. From 6pm until 9pm, there was one registrar present reviewing acute medical patients supported by one junior doctor. After 9pm until 8am, the medical registrar would provide cover for the AMU, emergency department and the medical wards with the support of one junior doctor on the AMU and one junior doctor on the medical wards. A consultant was available on-call and could be contacted and available within 30 minutes if required.
- At night, one registrar and two junior doctors covered the entire medical directorate. If the registrar was busy with a patient, this could mean junior doctors covered the medical directorate.
- There were two consultant cardiologists on-call for cardiac patients 24 hours a day, seven days a week trust wide.
- There were medical vacancies across the eight clinical areas at this hospital. Data for 30 June 2016 for medicine reported a vacancy rate of 12.2%; based on 7.85 whole time equivalent vacancies.
- From April 2015 and March 2016, Pilgrim hospital reported a bank and locum usage rate of 32.7% across medicine.
- Following our inspection, we requested information about the induction process for locum medical staff. Information provided by the trust included an induction pack which contained guidance on the computer systems, staff identification badge and computer access card. The trust commented that senior medical staff would receive a trust induction and the recruitment team would arrange contact with their fellow consultant. Junior doctors who would cover shifts would receive the induction pack only.

Major incident awareness and training

- A major incident plan version six (approved July 2016) was available for staff to access through the trust's intranet system. This detailed action to be taken by ward staff in the event of a significant incident within the trust or a major incident.
- During our inspection we found the major incident folder on the AMU contained information which was out-of-date. This included the major incident plan (review 2005), staff contact list (2008) and action cards (2005). We raised this with the nurse in charge who said they would address our concerns.
- During our unannounced, the major incident folder contained the current version of the major incident policy (approved July 2016) with the current action cards. The nurse in charge told us the staff contact list was in the process of being up-dated.
- Staff demonstrated an awareness of where to locate the major incident plan.
- Major incident training was not consistent for all staff; some staff told us they had received major incident awareness training.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because;

- Outcomes for patients were sometimes below expectations when compared with similar services at a national level.
- Care and treatment did not always reflect current evidence-based guidance. The trust did not follow national guidance for the administration of rapid tranquilisation medication.
- There was a pain assessment tool however it's use was inconsistent. There was a specialist pain team however; staff were unclear as to what this referral pathway was.
- The trust had not informed the Care Quality Commission (CQC) about any DoLS applications between September 2015 and September 2016. 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.
- Not all staff had the right qualifications, skills, knowledge and experience to do their job. Not all staff

had the training or completed competences recommended by the trust to care for patients with a tracheostomy or to care for patients receiving non-invasive ventilation.

- There was no policy for restraining patients but we found evidence that patients had received tranquilisation drugs in order to sedate them.
- During our unannounced inspection we found three patients who had their bed rails up despite there being no indication in their records that bed rails were required.

However, we also found:

- Medical services continued to participate in national audits relevant to their speciality. A range of local audits were also undertaken.
- Evidence based care bundles were in place and staff knew how to access these.
- The service demonstrated good multidisciplinary working across the service. This included support from community staff who attended meetings to discuss patient care.
- There was a colour coded system to signify assistance required for patients to maintain dietary and fluid requirements.
- Endoscopy services at this hospital were Joint Advisory Group (JAG) accredited.
- There were advanced and specialist nurse roles to support care delivery.
- A dementia care practitioner was available to support patients living with dementia.

Evidence-based care and treatment

- Staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). We reviewed five sets of patient care records. Five out of the five patients had received a venous thromboembolism (VTE) risk assessment and had preventative venous thromboembolism (VTE) medication if indicated.
- A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. During our inspection we saw a number of care bundles in place. Examples included; neutropenic sepsis, hyperkalaemia (raised amount of potassium found in the blood), community acquired pneumonia, chronic obstructive pulmonary disease (COPD) discharge, sepsis identification checklist and urinary catheters. Chronic obstructive pulmonary disease is a progressive, long-term disease of the lung. Staff we spoke with knew how to access these.
- We looked at trust policies including safeguarding adults, mental capacity act and deprivation of liberty safeguards, and the resuscitation and deteriorating patient policy and found they reflected best practice and were in date.
- There were a range of local audits undertaken by the trust, which included nutrition, patient observations, medication and tissue viability.
- Staff demonstrated understanding of an evidence based assessment tool to assess mental capacity. This included a two-staged form and a scoping tool with an ability to escalate the case of not sure. The safeguarding team supported staff with this process.
- A confusion assessment pathway was in place, which prompted staff to assess whether there was an existing dementia diagnosis, delirium or issues with memory and confusion. Each element had actions including conducting referral pathways.
- 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. We raised our concerns with the trust and action was taken to address this. During our unannounced inspection we found two patients who had been given rapid tranquilisation. Neither patient had a care plan to meet their needs if and when they became distressed. There was no evidence that other interventions had been used to de-escalate the patients.

Medical care (including older people's care)

Pain relief

- Nursing care records included care plans for pain. A pain assessment in advanced dementia (Abbey Pain Scale) was available for patients who could not verbalise and / or may have a cognitive disorder. However, staff we spoke with told us the use of this tool was not consistent across the medical directorate. We did not see this tool being used on the wards we visited.
- There was a specialist pain team to support patients and staff. A referral process was in place however, staff were unclear as to what this referral pathway was.
- We observed staff undertaking patient intentional rounding where pain assessments took place. Patient records reflected that this should take place hourly. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs. However, staff did not consistently complete intentional rounding charts hourly. We reviewed five patient charts three out of the five were incomplete.
- Of the five patients we spoke with all reported their pain had been managed.

Nutrition and hydration

- A nationally recognised malnutrition universal screening tool (MUST) was used throughout medicine to identify adults who were malnourished or at risk of malnutrition. The tool was included in the nursing admission pack, which staff completed on admission. Nursing staff re-evaluated the nutritional assessment throughout the patient's stay. Staff used this tool to inform care planning and identify any specific dietary requirements. We reviewed five charts all had a completed MUST assessment.
- On ward 6A and 6B there was a traffic light system to identify patients requiring levels of assistance to eat and drink. The dots were displayed on the patients' information board above their beds. The red colour identified full assistance required, amber identified some assistance and green identified no assistance was required.
- Ward 6B had different coloured drinking beakers and water jugs to signify how much assistance the patient required. This included red for full assistance required, blue for support and encouragement and green for independent.
- Protected mealtimes were in place across the medical wards. Protected mealtimes encourage hospitals to stop all non-urgent clinical activity on wards during mealtimes. During this time, patients could eat their meals without interruptions and nursing staff were available to offer help to those who needed it.
- On ward 6A, we observed that all staff on the ward stopped what they were doing at lunchtime and assisted in the serving of meals. Staff told us this was to ensure meals were given out in a timely manner.
- During one of our unannounced inspections we saw one patient who was laid in a semi upright position in bed, trying to eat porridge for breakfast. The patient spilt the porridge down herself. The health care assistant gave her a serviette but there was no communication with the patient and the patient was not asked if they wanted any help. We observed the patient continue to spill their porridge and the patient became agitated, however the healthcare support worker walked away. We escalated this at the time.
- Staff provided jugs of fresh water for all patients who were drinking. We saw that all patients had access to water jugs at the bedside, these were within patient's reach.
- On the stroke unit specialist trained nurses completed swallowing assessments for patients who had experienced a stroke. Speech and language therapists (SALT) were also available Monday to Friday to complete swallowing assessments. At weekends and out of hours the specialist registered nurses on the stroke unit completed swallowing assessments to ensure the patient was not left without adequate nutrition for any period of time.
- During an unannounced inspection we saw two infusion pumps alarming for two patients. One pump was administering intravenous fluids and one was infusing an enteral feed. The pumps had been alarming for over seven minutes. Staff walked by and no attempt was made to investigate and or address the cause of the alarms. We escalated this to the nurse in charge who did then attend to the pumps.
- During our unannounced inspection we saw a patient receiving their enteral feed through a nasogastric tube. The policy stated checks should be completed before administration of the feed or medication yet the records

stated the patient had received three feeds without any evidence of checks being completed. We also found the fluid chart was not completed despite a feeding regime insitu.

Patient outcomes

- The trust's 'rolling 12 month' Hospital Standardised Mortality Ratio (HSMR) for April 2015 to March 2016 was 101.5, which had decreased (was better than) from the previous year of 109 (April 2014 to March 2015). For March 2016, the HSMR was 97.62. 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 1.101 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.
- A statement provided by the trust stated they were working collaboratively with the Clinical Commissioning Group (CCG) on deaths within 48 hours of admission, out of hospital and sepsis.
- 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. From April 2016 to July 2016 SSNAP scored Pilgrim hospital at level A for seven out of 14 of the indicators on a scale where level E is the worst possible. For the remaining seven indicators Pilgrim hospital scored a level B for six and level C for one.
- Pilgrim hospital took part in the 2015 National Diabetes Inpatient Audit (NaDIA). Results showed the hospital had two scores better than, and 15 scores worse than, the England average. The indicator regarding 'foot risk assessment within 24 hours' was better than the England average at 29.41% compared to 28.66% nationally. We saw the trust had an action plan to address the areas where scores were below the England average. This included the introduction of diabetic link nurses on all wards who provided information to ward staff, received study days and fedback to the diabetes nursing team, plans to make insulin medication and administration as part of mandatory training and diabetic emergency training for junior doctors was to be accessed through the post graduate education centre.
- Pilgrim hospital took part in the 2013 to 2014 myocardial ischemia national audit project (MINAP). Results showed the hospital performed worse than the England average for the three indicators.
- For this hospital, results for the heart failure audit (2014 to 2015) were lower than the England and Wales average for ten out of the 11 standards.
- Between February 2015 and January 2016 medical patients at this hospital had on average a lower than expected risk of readmission.
- The elective specialties, clinical haematology and gastroenterology, had the largest relative risk of readmission however non-elective gastroenterology was higher than expected.
- Between March 2015 and February 2016, the average length of stay for medical elective patients at the Pilgrim hospital was 1.8 days, compared to 3.9 days for the England average. For medical non-elective patients, the average length of stay was 6.8 days, compared to 6.7 for the England average.
- In 2016, this hospital gained full Joint Advisory Group (JAG) accreditation for one year. We saw correspondence between this hospital and JAG dated 1 June 2016 confirming the award. 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.
- 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. For patients this means better experience, involvement and outcomes. Data for the reporting period July 2016 to September 2016 showed between 96.57% and 99.53% of patients were screened for dementia. This was above the target of 90% set by the clinical commissioners.

- The trust had been identified as an outlier for sepsis in August 2015. A sepsis outlier is where the trust performs worse than the national average. The trust had a task and finish group and an action plan had been developed to address this.
- We saw evidence of monthly audit results discussed at ward meetings.

Competent staff

- Appraisal rates at Pilgrim hospital for July 2016 for integrated medicine management were 12.5% and medicine was 66.5%. This was below the trust target of 95%. The appraisal rates for July 2015 for integrated medicine management were 100% and medicine was 80.4%.
- We saw evidence of a revalidation with the nursing and midwifery council (NMC) policy currently under ratification by the trust.
- We were told nurses on ward 7B received additional training to care for patients receiving non-invasive ventilation (NIV). At our unannounced inspection, the senior sister on ward 7B told us that all the registered nurses had received NIV training and were competent to care for patients receiving NIV.
- Due to the high numbers of agency staff used we were told on night shifts, patients requiring NIV were allocated to agency staff who had not undertaken competencies to care for patients requiring NIV. The nurse in charge was expected to support the agency staff as well as support their own patients. We therefore had concerns relating to the safety of patients who required NIV.
- We formally wrote to the trust notifying them of our concerns regarding the number of staff able to deliver care to patients requiring NIV. In response to that request, the trust provided a detailed plan outlining actions they were taking, and additional information which included evidence of teaching, a competency framework, trust clinical guidelines and a list of staff competent to care for patients requiring NIV; however, from the list of staff competency it was unclear how many of these staff were competent. A further information request was made to the trust to provide the most up to date training compliance figures for ward 7B. Data provided by the trust demonstrated that all staff were going to be trained by the 1 December 2016.
- Ward 7B was the designated ward for patients who had a tracheostomy. Nurses on this ward should have received additional training to care for these patients. Information provided by the trust demonstrated the training records for tracheostomy staff competence was not fully completed indicating staff members were not competent. We wrote to the trust for further information to confirm staff competence, information received demonstrated three staff fully trained and assessed as competent. The remainder of the staff were to be provided with training with this to be completed by the end of November 2016. However, it was not clear if this would include the assessment of staff competence, therefore, further information was requested. An action plan was also received which indicated how ward 7B would manage patients with tracheostomies until all staff were trained and deemed as competent. The plan included ensuring al staff were competent by the end of November 2016.
- Physiotherapists had protected time to take part in two weekly clinical supervision sessions. Topics discussed included training and development, concerns, minor issues and support.
- At this hospital, 11 health care assistants had completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers follow in their daily working life. The minimum standards should be covered as part of induction training of new care workers.
- Nurses on ward 7A (oncology) had completed specialist training provided by the trust appropriate to their role which included for example, cannulation, venepuncture and care of central venous catheters (used for the administration of chemotherapy or other medications).
- A clinical educator was based on all of the medical wards. They were a part of the nursing team and coordinated staff training. Staff told us training was difficult to access due to the availability of the courses and the demands of clinical work. However, on ward 7A the clinical educator had undertaken additional training to be able to deliver basic life support training to nursing staff on the ward.
- Dementia training was not mandatory, however we saw evidence of a training needs assessment (2015/2016) identifying staff recommended to undertake dementia awareness sessions and all nursing staff working within the care of older people and complex care were expected to complete the 'understanding frailty competency' workbook. The trust informed us this was not monitored as dementia training was not mandatory

however for the period April 2015 to October 2016, 270 staff had received dementia awareness training at Pilgrim hospital. We could not determine the number of nursing staff who had completed the frailty competency workbook. We requested additional information from the trust for numbers of staff who were not trained, however this was not provided.

- The endoscopy unit had one consultant nurse and four nurse endoscopists who worked at the trust.
- The cardiac unit had a number of advanced cardiac practitioners who rotated between Pilgrim and Lincoln hospital.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient care and treatment; with involvement from general nurses, medical staff, allied health professionals (AHPs), social workers and specialist nurses. All staff we spoke with told us there were good lines of communication and working relationships between the different disciplines.
- On ward 6A and 6B, a ward which provided care for elderly patients, 80% of whom were living with dementia, morning 'board rounds' took place Monday to Friday. Staff involved included, the responsible consultant, junior and senior doctors, AHPs, the patients nurse and a social worker. Board rounds were an opportunity for these key professionals to discuss patients' care pathways and discharge plans.
- A mental health liaison team offered 24-hour advice and support to patients and staff. On the AMU they attended the morning handovers to identify any patients who may require additional support or who may be at risk. Staff told us they contacted the team by telephone and were responsive to referrals for patients.
- On the oncology ward, there was an acute oncology nurse available Monday to Friday 9am to 5pm who supported patients both on the ward and in other areas to ensure continuity of patient care.
- Specialist nurses for example, tissue viability nurses (TVNs), dementia practitioners, heart failure nurses and discharge liaison nurses were available to provide face-to-face training, guidance and support to staff within the medical wards.

Seven-day services

- Access to diagnostics services was provided seven days a week for patients who were acutely unwell, which included endoscopy, computerised tomography (CT) or magnetic resonance imaging (MRI) scans. The trust provided these services across the different sites, which meant greater travel for patients. A CT scan is a three dimensional X-ray. MRI is a scan which uses radio waves to create detailed images of the organs and tissues within the body.
- Pilgrim hospital's pharmacy operated between 9am and 5pm Monday to Friday and 9:15am to 12:15pm on Saturday. An out-of-hours pharmacy team provided a home based service for urgent advice and supplies. There was access to an out of hours emergency medication room through the site manager to ensure timely access to medicines, this was in addition to the pharmacy stocks held by the ward.
- Physiotherapy and occupational therapy were available 8:30am to 4:30pm Monday to Friday. The physiotherapists offered a 24-hour on-call service for the respiratory service seven days per week.
- The endoscopy unit opened six days per week with a Sunday service available every fourth week.
- Out of hours care was provided by a 'hospital at night' team, which consisted of nurses and clinical support workers. It offered additional acute care delivery such as cannulation and the taking of blood samples.
- A mental health liaison team was available 24 hours a day, seven days per week.

Access to information

- Staff had access to information from the medical records, which were mostly stored on site and could be requested 24 hours per day.
- Staff used a smart card system to access online records as well as diagnostic results and discharge information in a timely way.
- Staff used an electronic, hand held tablet device which provided blood and x-ray results with the ability to access and enter patient observations such as blood pressure, pulse and temperature.
- An electronic discharge document (EDD) was sent to each patient's GP as they were discharged from the hospital's electronic system.
- There was a secure, electronic referral form for social services.
- Agency staff did not have access to the electronic information but could request for information through one of the trust nurses if required.

- The discharge nurses were able to communicate with the GPs and the community nursing service through an electronic patient information management system. This allowed improved links with the community and improved communication.

Consent, Mental Capacity Act and 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. As of 31 August 2016 training compliance for medical and non-medical staff for safeguarding adults was 61% and 80% respectively. MCA training was 76% for October 2016.
- Staff had some understanding of the MCA and consent. We saw consent to care and treatment was mostly obtained in line with legislation and guidance and patients were supported to make decisions. However, one patient had received treatment without a mental capacity assessment or DoL's application in place.
- 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 were wards with restricted access, which meant that patients had to ask a member of staff to open the doors. Patients relied on nursing staff to enable them to leave the ward.
- Staff used a scoping tool designed to assist in the identification of those patients who may require a formal DoLS referral.
- 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 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, 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.
- During our unannounced inspection on 19 December 2016, we found three patients who had their bed rails up. However, when we reviewed notes there was no indication these bed rails were required.

Are medical care services caring?

Inadequate

We rated caring as inadequate because;

- We observed patients basic needs were not met. Patients were not always treated with privacy and dignity.

- On wards 6A and 6B we observed instances where staff had not taken steps to maintain a patient's privacy and dignity.
- On Ward 6A we observed one instance where a patient was distressed about the care being delivered to them but nursing staff did not speak to the patient, stop what they were doing or attempt to reassure the patient in any way.
- On ward 6A, we observed treatment being delivered which did not show any respect for the patient or for the effect the treatment might have on them.
- On ward 6A, staff did not always ensure patients had call bells and we observed delays in call bells being answered on wards 6A and 6B.
- Two out of eight relatives we spoke with were unhappy with the care their relative received. These related to delayed diagnosis, not able to reach drinks or the call bell, lack of communication and poor hand hygiene. We received information from relatives and or carers of patients after our inspection stating perceptions that patients were not being cared for in a kind and respectful manner

However, we also found:

- Most staff were polite, caring and friendly in their approach to the delivery of patient care. Some 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.
- The hospital Macmillan nursing team offered counselling and support to patients and staff on the oncology ward.
- 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.

Compassionate care

- We did see a number of examples of good care but we witnessed care being delivered to patients which was not compassionate.
- Staff mostly maintained the privacy and dignity of the patients they cared for. However, we observed instances where staff had not taken steps to maintain 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 could see what was happening. On both occasions we prompted staff to close the curtains.
- We saw other examples of patients not being treated with dignity or respect on ward 6A. We saw one patient on a commode behind partially drawn curtains.
- We observed another instance where care was being delivered to a patient behind closed bay curtains, but the window curtains were not closed which meant a reflection of the patient could be seen.
- We witnessed an anxious patient having care delivered by two Health Care Assistants. There was no interaction with this patient for over three minutes despite the patient shouting out. There were no attempts to calm or reassure the patient. We heard the patient shout out "You are frightening me to death."
- We observed a used commode had been left in the middle of a bay on ward 6A whilst food was being served.
- During our announced inspection on ward 6A and ward 6B, we observed instances where the nurse call bell was ringing unanswered for over ten minutes.
- During our unannounced inspection we found not all patients on ward 6A had their call bells in reach.
- During our unannounced inspection we observed a registered nurse on ward 6A administer a cold water flush down a patients a patients naso gastric tube (NG tube) whilst the patient was asleep. A naso gastric tube is inserted through patients nose into the stomach and can be used to give a patient nutrition. No communication was observed between the nurse and patient and the patient was visibly distressed when the cold water entered their stomach. This did not afford the patient dignity and showed a lack of compassion for this individual patient.

- During one of our unannounced inspections we found two patients who had NG tubes. There was no evidence of oral care being given and their mouths appeared visibly dry and their lips appeared cracked.
- During our unannounced inspection we were told the night lights had not been in working order on ward 6A for four months, this meant the night staff had to turn the main ward bay lights on to deliver care to an individual patient during the night, this is turn may distur other patients sleep. Following our inspection the trust told us the Head of Nursing was working on this with Estates and an options appraisal was being developed that would address the lights, power and call bell. Due to the infrastructure of the building, the work required is more complicated.
- During our unannounced inspection we were told a patient had deceased on ward 6A at 03:50 but was still on the ward at 07:30. Staff told us porters had a four hour window for collection of the deceased to take them to the mortuary. This did not afford deceased patients respect and could be distressing for other patients and relatives. Following our inspection the trust told us that there was not a four hour window and any deceased patients would be transferred to the mortuary at the earliest possible time, they were unsure as to why we were told this.
- We reviewed the NHS Friends and Family Test (FFT) results in medicine from October 2015 to October 2016. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Results showed the average response rate to be 34%. This was better than the England average of 31% for the same reporting period. Results from this reporting period showed between 67% and 100% of respondents would recommend the NHS service they had received to friends and family who may need similar treatment or care.
- The patient experience team collected correspondence received from feedback in the form of cards or letters. The team provided information of the total of responses to each ward. The ward displayed figures under the heading 'counting compliments'. Between September 2015 and September 2016 the medical directorate received 775 compliments of those ward 6B received 384, ward 7A received 169, ward 8A received 98, ward 9A had a total of 87 and ward 6A received 37.
- There was a confidential area at the reception desk in the endoscopy unit to allow patients to relay information without being overheard by other people.
- We spoke with 13 patients and eight relatives during our inspection. Feedback from patients was mainly positive with nine out of 10 patients commenting positively about their hospital stay.
- Two out of the eight relatives we spoke with 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.
- 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

Understanding and involvement of patients and those close to them

- Patients told us they felt involved to varying degrees in their care and treatment.
- Staff on the oncology ward offered a 'chemotherapy talk' with patients and their relatives to share information about treatment processes, expectations and possible treatments patients might encounter. Patients and relatives told us they felt informed about the care and treatment they received.
- The stroke association volunteer visited the stroke unit every Tuesday to offer support to patients and their relatives. A relative told us they felt supported through the volunteer service.
- 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 were in attendance at the hospital. Patients and relatives told us they felt this was a good idea as it allowed them to be involved.

Emotional support

- 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. We saw a clinical nurse specialist for stroke services supporting a patient who had suffered a stroke.
- 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.
- The hospital Macmillan nursing team offered counselling and support to patients and staff on the oncology ward.
- 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 medical care services responsive?

Requires improvement

We rated responsive as requires improvement because;

- 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.
- Staff raised concerns related to one computerised tomography (CT) scanner (introduced in 2009) available for patients. This scanner was periodically out of use due to predicted servicing and it breaking down . Medical staff told us the length of time taken to transfer patients to Lincoln County hospital decreased the best time for treatment for patients with a hyper acute stroke who required thrombolysis.
- Systems were not robust to identify vulnerable patient groups which included patients living with dementia and patients with learning disabilities.

However, we also found:

- 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.
- A trusted assessor for care homes worked with the discharge team. The role provided a named link between the care home and the hospital to support a timely and safe discharge from hospital to a care home.
- From September 2015 to April 2016 the trust reported no mixed sex breaches.

Service planning and delivery to meet the needs of local people

- A transient ischaemic attack (TIA) rapid access clinic was available seven days a week for patients who may have experienced a TIA (mini stroke). Referrals to the clinic were by the patient's own GP or the emergency department. Staff received referrals by email and triaged them every morning.
- Within oncology/chemotherapy, a 24-hour telephone service was available for direct patient advice, support and admission. The calls were triaged using a triage log sheet and depending on the outcome, the patient could be sent directly to the appropriate service.
- In planning services, the directorate appointed a number of specialist nurses and clinical educators across the site to support ward provision and to meet the needs of patients requiring specialist care.
- There was a plan for the ambulatory emergency care unit and the AMU to work better together and be a cohesive unit.

Access and flow

- Three site management meetings took place each day (8am, 12.30pm, and 3pm) where the site duty manager and bed managers discussed and assessed the flow of patients through the hospital. This included identifying 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.

Medical care (including older people's care)

- Patients were admitted to the AMU through the emergency department or GP referral. A doctor and a nurse would assess the patient and prescribe a plan of care. The consultant aimed to review the patient within 12 hours.
- Stroke medicine provided timely access to initial assessment, diagnosis or urgent treatment of those patients who may be experiencing a stroke. There were 28 beds at this hospital which included two 'hyper acute' beds. Hyper acute refers to those patients in the early stages of stroke. Specialist trained nurses reviewed any patients who may be experiencing a stroke who were admitted to the emergency department or who may already be an inpatient. A rapid assessment protocol was followed to ensure patients received prompt treatment on the stroke pathway, including computerised tomography (CT), thrombolysis and swallowing assessment. Thrombolysis is a treatment used to dissolve dangerous blood clots in blood vessels.
- Staff we spoke with told us there was one computed tomography (CT) scanner available for patients to use at the hospital. Staff told us the scanner (introduced in 2009) was periodically out of use due to predicted servicing and it breaking down. The clinical leads told us there was a mobile CT scanner available which was situated outside, at the rear of the hospital. However, we were told the hospital trolley did not fit into the mobile scanning unit; therefore, patients had to be transferred onto the trolley for the mobile unit before entering the scanning area if a scan was required. Staff told us of one occasion when they had transferred a patient from the hospital trolley to the mobile unit trolley at the entrance to the mobile unit which was outside. Staff on the stroke unit told us if the hospital CT scanner was out of use the stroke unit alerted the East Midlands Ambulance service to re-divert patients who were experiencing a hyper acute stroke directly to the Lincoln County hospital to receive a CT scan. However, medical staff told us the length of time taken to transfer patients in the ambulance decreased the best time for treatment for patients with a hyper acute stroke who required thrombolysis.
- The stroke unit had an assisted discharge team, which included dedicated stroke unit physiotherapists, occupational therapists, speech and language therapists, dieticians and social workers. This was available for patients to enable patients to be discharged directly back to their own home with a package of care.
- The hospital had recently introduced an electronic system to improve patient flow. It highlighted to staff early in a patients care journey what resources were likely to cause a delay so that staff could act to prevent delays at the end of the patients stay. The system allowed staff to communicate with other disciplines including radiology and physiotherapy to prevent potential delays in a patients discharge.
- Bed occupancy information was requested for medical services at Pilgrim hospital; however, a statement provided by the trust demonstrated only trust wide data was collected.
- In June 2015, the admitted and non-admitted operational standards were abolished, and the incomplete pathway standard became the sole measure of patients' legal right to start treatment within 18 weeks of referral to consultant-led care. 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 latest figures for September 2016 showed 76% of this group of patients were treated within 18 weeks. No specialties were above the England average for admitted RTT (percentage within 18 weeks). The specialities of cardiology, dermatology, gastroenterology, general medicine, elderly care medicine, neurology, rheumatology and thoracic medicine were all below the England average for admitted RTT.
- Throughout our inspection, senior staff told us the trust's outlier policy was being updated. Following our inspection, we asked the trust to share their outlier policy with us. The trust provided the new outlier policy for medicine (October 2016).
- During our inspection, there were six medical outliers. Medical outliers are patients who are receiving care on a different speciality ward for example a medical patient on a surgical ward. The trust had systems in place to monitor medical outliers throughout the trust. There was evidence of a daily medical review and an 'oversight' of the patient's progress including estimated date of discharge, which was held by the site manager.

Information provided by the trust demonstrated from April 2016 to July 2016 the total number of outliers for medicine at Pilgrim hospital was 2,501. We were not able to bench mark this in line with similar services.

- A discharge lounge staffed by nursing staff was used to accommodate medically stable and independent patients while waiting for tablets to take out (TTO) or transport prior to their discharge home. This enabled faster availability of ward beds. .
- The wards had discharge nurses to support the ward teams on wards 7A, 7B, 8A, 6A and 6B. Discharge nurses had responsibility for patient flow and discharges in their ward areas. We saw discharge nurses on the wards we visited.
- Discharge planning for patients began on admission to hospital. We saw evidence of discharge planning by medical, nursing, allied health professionals (AHPs) and social care staff. There were key actions and goals set for the patient in order to be medically fit for discharge.
- A trusted assessor for care homes worked with the discharge team. The role provided a named link between the care home and the hospital to support a timely and safe discharge from hospital to a care home. The role also included assessments of patients on behalf of the care home, ensuring discharge documentation was completed, liaised with the care home about discharge arrangements, acted as a point of contact when residents of a care home were admitted and worked with the hospital and the care home to resolve any issues related to discharges.
- Data provided by the trust for the period July 2015 to June 2016 showed 60% of medical admissions did not move wards during their hospital stay. However, 40% moved wards on one or more occasions. During our inspection, a comment received by a patient was related to having moved wards more than four times and being asked to move again.
- 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 what staff were required to make the ward safe.
- Data for the reporting period January 2016 to June 2016, showed across eight clinical areas 595 patient transfers had occurred after 10pm. These included wards 6A and ward 6B (69) ward 7A (98), ward 8A (103) ward 7B (106) moves and coronary care unit (110) moves after 10pm at night. We were not able to bench mark this in line with similar services.
- Following our inspection we asked the trust if they monitored delayed transfers of care in medicine. Data provided for December 2015 to July 2016 demonstrated 463 patients whose transfer of care was delayed. Reasons for delayed transfers of care for the medical specialty were not provided.
- Data provided by the trust demonstrated from October 2015 to October 2016 there was 7721 discharges out of hours for Pilgrim hospital compared to 2707 for Lincoln hospital for the same reporting period. Reasons for the out of hours discharges were not submitted.
- At the time of our inspection a frailty service was due to be implemented (28 November 2016) which included an elderly care consultant working in the emergency department Monday to Friday 8am to 5pm. There were to be four male and four female beds available for a maximum of a 72 hour period to allow a frailty assessment, review and discharge home.
- All of the medical wards included single-gender accommodation, which promoted privacy and dignity. From September 2015 to April 2016, the trust reported that there were no times when male and female patients were treated in the same bay.

Meeting people's individual needs

- 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.
- There was access to a mental health liaison team, which was available for patients within the hospital 24 hours a day. Staff told us the team were responsive and would be contacted for any patients with specific mental health needs.
- 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.

Medical care (including older people's care)

- 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 was yellow pictorial signage identifying where the toilets were on ward 6B to help patients living with dementia.
- There was no electronic system in place for identifying patients living with dementia or learning disabilities at this hospital.
- There were two learning disability specialist nurses employed by a neighbouring mental health trust who provided liaison support for Pilgrim hospital. 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.
- Staff told us they used the 'This is me' booklet for patients living with dementia. We were told a member of the Alzheimer's 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.
- 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.
- On ward 7B there was the facility for patients requiring bariatric care and treatment. Bariatric medicine provides care, treatment and management of obesity.
- The discharge lounge had four volunteers who served hot drinks to patients.
- 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.
- All the medical wards were divided into bays that provided single gender accommodation with designated male and female facilities in the bays.
- We observed staff providing one to one care on some of the medical wards. This meant the patient was being monitored and kept safe from harm or risks. However, staff told us they sometimes struggled to get one to one support for patients requiring this. This meant a member of staff already counted in the staffing numbers would have to provide one to one care if an additional staff member had not been made available.
- On ward 6A, we saw that some patients were self-caring and were able to eat independently. These patients sat in their chair to eat their meal. However, some patients being nursed in bed relied on staff to support them to eat their meal. We were concerned that patients who were sleeping were not always alerted that their meal had arrived and these patients were not suitably repositioned to eat their meal. We saw a patient in a side room who was slumped in their bed whilst attempting to eat their meal. We raised this with staff on the ward who took immediate action to support this patient to reposition. Another patient was being assisted to eat by a family member when the patient started coughing and choking on their meal. Action was then taken to reposition this patient into a more upright position to ensure their safety.
- A variety of food was available to meet people's individual needs. This included special dietary needs such as gluten intolerance, diabetic, Asian food and vegetarian options.
- Wards had a range of information leaflets available, which included topics such as infection control, the stroke unit and how to make a complaint. There were also leaflets on diagnosis/condition specific information such as a heart attack, blood thinning and lumbar puncture. Patient information and advice leaflets were available in English, but we did not see leaflets available in any other language or format. A lumbar puncture is a procedure to take fluid from the lower part of the spine to diagnose illness or disease.
- 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 also received free parking whilst they attended at the hospital.

Medical care (including older people's care)

- 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.
- During out unannounced inspection on 19 December 2016 we found 12 out of 17 patients on ward 6A did not have access to call buzzers (they were either on floor or on the panel behind the bed).

Learning from complaints and concerns

- Monthly complaints reports were shared with the patient experience committee and the quality governance committee. A patient experience report was presented at trust board level.
- Monthly scorecards at site level were provided and a site report was produced which included number of complaints received, number of complaints still open, percentage responded to within timescale, percentage overdue complaints, breakdown of overdue complaints at business unit level and any trends identified.
- Complaints service reviews and performance were discussed at Clinical Executive Committee and Executive team meetings.
- Completed complaints were a standing item on specialty governance meetings.
- We saw posters and leaflets on the wards and in clinical areas of how to raise a concern or a complaint.
- Between June 2015 and May 2016, there was a total of 76 complaints received in medicine at Pilgrim hospital. The top three themes for complaints within this service were; clinical treatment (84), communication (36) and patient care (33).
- A complaints officer and complaints advisor were available to support patients and relatives who wanted to make a complaint.
- Ward sisters were involved in investigating complaints in their areas. All staff we spoke to said knew how to deal with complaints and concerns. Nursing staff told us they would try to resolve complaints quickly and locally whenever possible. Managers for the appropriate speciality produced actions plans and identified learning. Staff we spoke with said managers shared learning from complaints and concerns. Managers shared learning through team meetings, safety briefings, newsletters and emails. We saw an example of a ward newsletter sharing learning with staff.

Are medical care services well-led?

Inadequate

We rated well led as inadequate because

- Staff were not clear of the direction the service was heading despite the trust having a clear vision and strategy for medicine. Following our inspection the trust told us there were extensive systems in place that evidenced that the Clinical Strategy was communicated to staff demonstrating that the Trust has a clear vision and strategy for all services including medicine
- Leaders within the service had failed to identify and act on issues about risk and patient safety within medicine.
- There were some risks we identified that posed a risk to safe care and treatment of patients that had not been recognised. These included no availability of a gastrointestinal bleed rota, not all staff were trained as competent to deliver care to patients receiving non-invasive ventilation and tracheostomy care, sepsis six treatment targets were not being met, mandatory and safeguarding training was below trust target, ligature risk assessments
- Poor standards of care had become normalised by some staff in some clinical areas.
- Although we saw some evidence of challenge we were not assured that this was sufficient. This meant some staff lacked the capability to recognise what good care looked like.
- We were not assured leaders within the hospital had oversight of the clinical care being delivered on the wards.
- We were not assured local leaders had the necessary knowledge and capability to lead effectively.
- Leaders were out of touch with the clinical care being delivered on the front line. The local leadership team had failed to identify risks to patient safety and that patients basic needs were not always being met and there was a lack of clarity about how staff were held to account.

Medical care (including older people's care)

- Cross-site working was inconsistent across medicine at Pilgrim Hospital.
- We received mixed feedback from staff about morale and feeling they could rasie concerns and were listened to.

However, we also found:

- A number of staff told us the culture had improved in the last five years but there was still a need for improvement. Many staff commented the trust was safer than it used to be.
- Staff spoke positively of the 'United Lincoln Hospital Trust Together' social media page, which included general information up-dates, praise, encouragement and 'thank you' comments to staff and departments..
- 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.

Vision and strategy for this service

- Medical care was provided at this hospital as part of the medicine clinical directorate.
- Whilst there was a clinical strategy in place, it wasn't articulated with staff. Staff were not clear of the direction the service was heading. This had led to some staff feeling uncertain about the future of the service. Following our inspection the trust told us there were extensive systems in place that evidenced that the Clinical Strategy was communicated to staff demonstrating that the Trust has a clear vision and strategy for all services including medicine,
- United Lincolnshire Hospitals had a clinical services strategy for 2016 to 2021. This included reviewing current services, refining the delivery of medical care and meeting the health needs of the local community.
- Most of the staff we spoke with could inform us of the trusts overall vision which was 'consistently excellent and safe patient-centred care for the people of Lincolnshire, through highly skilled, committed and compassionate staff working together' and values which included 'ensuring clinical and financial stability', 'patient centred', 'safe' , 'excellence', compassion' and respect.

Governance, risk management and quality measurement

- Information provided by the trust demonstrated there was a ward to board governance structure for medicine at pilgrim hospital but this was ineffective in identifying lapses in the quality of care being delivered. Leaders within the service had failed to identify and act on issues about risk and patient safety within medicine.
- A trust risk register held for medicine had 29 risks identified, 19 of which were for Pilgrim hospital. Risks included a description, controls in place to mitigate the risk and, a summary of actions taken. Senior leads and ward sisters cited staffing and environment as their top risks.
- However, there were risks we identified that posed a risk to safe care and treatment of patients but the trust was not aware or did not recognise these risks within medicine. These included no availability of a gastrointestinal bleed rota, not all staff were trained as competent to deliver care to patients receiving non-invasive ventilation and tracheostomy care, sepsis six treatment targets were not being met, mandatory and safeguarding training was below trust target, ligature risk assessments had not been undertaken in the medical admissions unit and ligature cutters were not available.
- Clinical governance meetings in the different services were undertaken monthly . We saw meeting minutes from AMU, stroke services, cardiology, gastroenterology, elderly care and respiratory services. We saw evidence of incidents, complaints, education, training, clinical effectiveness and risks on the risk register discussed.
- The first trust wide business unit meeting for medicine had taken place in July 2016. The meeting provided an opportunity for clinicians from all specialities to come together to discuss factors affecting the business unit as well as share learning. The business unit meeting fed into the trust's Quality Performance and Improvement Committee (QPIC), patient safety and clinical effectiveness committee (PSC) and the hospital management group (HMG). These groups fed into the upward report that was presented to the trust's Quality Governance Committee.
- Staff told us there was no Quality and Safety Officer (QSO) for the medicine directorate. The QSO's role was to ensure all incidents, complaints and claims were discussed at governance meetings and that learning

was shared with staff and the rest of the organisation. Following our inspection the trust informed us there was a QSO who was not around at the time of our inspection and that during the absence of the medical QSO, additional QSO support was being provided by other members of the team.

- We saw some evidence of incidents, complaints and compliments discussed at team and ward meetings but we were not assured there was a robust incident management procedure in place. Incidents were not always reported, investigated or learning identified and shared in a timely manner.
- A complaints manager covered the entire trust and was part of a small team, which included a complaints manager and an administrator. The complaints manager was responsible for a team on each of the three hospital sites. The complaints manager reported to the deputy chief nurse.
- A business case had also been made to recruit two full-time sepsis nurses, one of which would be based at this hospital. There was also a plan for the roll-out of an electronic learning package. The associate medical director told us they were confident there would be an improvement in sepsis management and treatment within six months of our inspection.
- Information was collected throughout the medicine business unit through a safety and quality dashboard (SQD) this included ward performance on falls assessments, Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) forms, physiological observations, sepsis, nutrition, tissue viability and patient dignity. The quality metrics had not identified any of the concerns we identified during our inspection.

Leadership of service

- The service leaders consisted of a clinical director, operational service manager, head of nursing, two matrons and heads of service for stroke, respiratory, elderly care, diabetes/endocrinology, accident and emergency and emergency medicine with vacancies in gastroenterology and rheumatology. This provided senior leadership from a nursing, medical and operational team.
- We were not assured there was sufficient professional challenge given to the nursing staff. This meant some staff lacked the capability to recognise what good care looked like. Poor standards of care had become normalised by some staff. We were not assured local leaders had the necessary knowledge and capability to lead effectively.
- We were not assured leaders within the hospital had oversight of the clinical care being delivered on the wards. Leaders were out of touch with the clinical care being delivered on the front line. The local leadership team had failed to identify risks to patient safety and that patients basic needs were not always being met. There was a lack of clarity about how staff were held to account.
- Staff we spoke with told us the matron visited the ward areas daily to review the current staffing and to offer support and guidance if needed. We saw this happened on all of the wards we visited.
- Some staff told us the head of nursing had visited some areas and staff felt she was supportive and approachable. However, some staff told us they did not feel supported or able to approach senior members of staff for support.
- There were mixed feelings about the responsiveness of the executive management team across the trust. Staff we spoke with at Pilgrim hospital expressed the feeling of a lack of priority by the board. Staff gave examples of meetings being cancelled, which were arranged to discuss cross-site working and safety implications for medicine at Pilgrim hospital. These examples included the concerns related to the absence of a GI bleed rota and one computed tomography (CT) scanner which was periodically out of use due to predicted servicing and it breaking down.
- The medical leads told us they felt they were supportive of one another.
- Staff articulated their view of cross-site working as 'feeling like the poor relative' and 'not given sufficient priority'. One staff member told us they felt 'left out' and 'Pilgrim was not seen as an equal partner'.
- Some services were managed trust wide, which included oncology, haematology, neurology, and cardiology. Other services were managed locally at Pilgrim hospital, which included care of the elderly, diabetes, respiratory, gastroenterology, acute medicine, and stroke.
- Between April 2015 and March 2016 at Pilgrim hospital, the average turnover rate for nursing staff was 12.4% on the medical wards, which was based on 37 whole time equivalents leaving.

Medical care (including older people's care)

- The sickness rates for nursing staff at Pilgrim hospital on the medicine wards was 6.67%, the number of full time equivalent (FTE) days lost was 5,678.65.
- Between April 2015 and March 2016 at Pilgrim hospital, the average turnover rate for medical staffing was 71.88% on the medical wards based on 44 whole time equivalent staff leaving.
- The sickness rate for medical staff at Pilgrim hospital on the medicine wards was 1.08%. The number of full time equivalent (FTE) days lost was 238.
- Appraisal rates at Pilgrim Hospital within integrated medicine for July 2016 were 66.5% and 12.5% for integrated medicine management. This was lower than the trusts target of 95%. We noted the appraisal rates were significantly higher in July 2015 (100% in integrated medicines management and 80.4% in integrated medicine).

Culture within the service

- A number of staff told us the culture had improved in the last five years but there was still a need for improvement. Many staff commented the trust was safer than it used to be.
- We received mixed feedback from staff. Some staff we spoke with told us they were supportive of each other; felt there was open communication between the ward managers and the medical staff. Some staff told us they were not afraid to voice their opinions. Where as other staff told us they didn't feel listened to and their concerns were not acted upon or taken seriously.
- Some medical staff expressed concerns about not feeling they were listened to by leaders with the trust.
- We spoke with some nurses who felt the pressure being placed on them was becoming too difficult and it had seriously impacted on staff morale. One nurse told us they felt they were putting their nursing registration at risk but the senior managers did not listen to their concerns.
- One staff member told us the Chief Executive had visited a ward at night and spoke with staff to seek their views. However, the majority of staff did not feel their opinion was sought by the local leaders within the hospital.
- We were told by three members of staff that they felt the hospital leaders did not want to listen to any concerns for fear of implications for the trust.
- Morale was often described by staff as being low.
- Cross-site working was inconsistent across medicine at Pilgrim hospital. In stroke services, staff said cross-site working and communication was limited, this was also the same for the acute medical unit (AMU). However, we were told the matron for oncology worked over the three sites (PAN trust). This service had unified pathways and staff attended meetings together.
- Staff articulated their view of cross-site working as 'feeling like the poor relative', 'not given sufficient priority' and 'Pilgrim was not seen as an equal partner'.
- The organisation recognised long service and awarded staff for their commitment to the organisation.

Public engagement

- Patient and carer feedback was included in ward team minutes highlighting communication as one of the issues.
- The medical directorate took part in the friends and family test (FFT), and results were publicly displayed in all ward areas. Response rates were better than the England average for medical wards at Pilgrim hospital.
- The patient experience team collected correspondence received from feedback in the form of cards or letters. The team provided information of the total of responses to each ward. The ward displayed figures under the heading 'counting complements'.
- There were patient information leaflets across the medical directorate, which included 'Tell us your experience' forms and complaints leaflets.
- We saw results from a patient satisfaction survey (March 2016) for the diabetic eye screening programme which had 287 responses from service users. It concluded the majority of patients were happy with the service; however, more seats were recommended in the unit.

Staff engagement

- Staff attended ward meetings; we saw evidence that the minutes of these were accessible in folders in the staff rooms and on staff notice boards. Staff also told us the minutes were sent to them electronically.
- Staff spoke positively of the 'United Lincoln Hospital Trust Together' social media page, which included general information up-dates, praise, encouragement and 'thank you' comments to staff and departments..
- The chief executive wrote a monthly blog and newsletter to staff, which staff spoke positively about.
- Staff said they contributed to the staff survey and listening into action (LiA), however some staff said they had not heard much about this recently.

- Staff on the stroke unit had a suggestion box for staff to share ideas for improvements. Those implemented included clocks and mirrors for patient use and fund raising for new chairs and notice boards.
- Staff on the AMU had a staff suggestion board for staff to share ideas for improvement. Some of the suggestions implemented included open access to their manager and alterations to the referral book to include more information about the patients' needs.
- Staff awards were held annually to recognise staff contribution and achievement. Categories included 'extra mile', 'team of the year', 'compassion and respect' and 'great patient experience'. For 2016 434 nominations were received, 100 of those received from patients. Nominations for the 2017 awards were being advertised.

Innovation, improvement and sustainability

- Following a successful project across Boston an innovative service funded by the Bromhead Charity which provides medical, nursing and therapy support to residents in care homes had been rolled out across Lincoln. The project involved a team of doctors, nurses, physiotherapists, occupational therapists and a nutritionist who visited nursing and residential homes in the Lincoln area. The team assessed every resident of every home, which included reviewing medications, assessments of mobility, mental capacity, cognition and future care needs. The aim of the team was to prevent hospital admission. Results indicated for the first three months of the team visiting one care home they had reduced the number of hospital admissions by 64% compared with the previous quarter. The team aimed to visit every nursing and residential home over the next two years which would include 1,000 people resident in 22 homes. The service was nominated for a national award in recognition of how it reached out to the local community to improve care for the vulnerable population group.
- Ward 6B had implemented a coloured beaker system to signify the level of assistance a patient required.
- 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.

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

United Lincolnshire Hospitals NHS trust provides a range of surgery and associated services at Pilgrim Hospital based in Boston. The surgical directorate is subdivided into five business units which include theatres and pain, head and neck, orthopaedics, general surgery and Bostonian Ward (a private and NHS ward). Each surgical business unit is led by a clinical director, senior business manager, head of nursing and matron.

The surgical unit at Pilgrim Hospital includes 126 inpatient beds across five wards.

There are 11 theatres carrying out elective and emergency general surgery, vascular surgery, urology and orthopaedic surgery at this hospital. We visited the all five surgical wards in addition to the recovery and theatre areas.

We used a variety of methods to help us gather evidence in order to assess and rate the surgical services. Before the inspection, we reviewed performance information received from and about the trust. During the inspection we spoke with eight patients and four relatives, five doctors, two anaesthetists, three managers, two physiotherapists, two dieticians, six registered nurses, two healthcare support workers, three administration staff and two operating department personnel. We observed the care delivered by theatre and ward staff including the environment in which it was delivered. We reviewed eight sets of patient clinical records, ten prescription cards trust and the electronic system used to store patient information on the wards.

Summary of findings

Overall we rated surgical services as good because:

- Staff recognised concerns, incidents or near misses and gave us example of when they may report these.
- Staff said they received feedback following raised incidents and could give examples of where learning from incidents had taken place.
- Equipment checked was within its service date and new equipment was evident across the service.
- Most clinical areas were visibly clean, uncluttered and well organised.
- We observed staff providing kind and compassionate care to patients and their relatives in all areas we visited.
- Friends and Family Test data (FFT) showed an average of 86% of patients on surgical wards said that they would recommend the service.
- Staff within this service showed a commitment to improving services and felt well supported by senior staff.
- Senior staff were well respected and valued by staff who described them as dedicated and hardworking.

However;

- Staff knew how to report incidents and what should be reported but incidents remained open on the system.

Surgery

- The trust results in the National Emergency Laparotomy Audit showed out of 11 measures only two areas were compliant with eight measures amber and one red.
- Patient records were stored in unlocked trollies, staff told us that new locked trollies were being delivered to those wards that currently did not have them but had not arrived during this inspection.
- There was no formal psychologist or counselling support for vascular patients following amputation.
- Medical outliers were admitted to the surgical wards, which resulted in cancelled operations which was outside the control of this service.
- Risks were not always dealt with appropriately or in a timely way. For example, the absence of emergency call bells on the surgical wards had been on the risk register since 2014 but minutes at the governance performance meeting in May 2016 showed that the risk remained unresolved.

Are surgery services safe?

Good

We rated safe as good because:

- Staff recognised concerns, incidents or near misses and gave us example of when they may report these.
- Staff said they received feedback following raised incidents and could give examples of where learning from incidents had taken place. The ward patient information boards displayed the number of incidents within a ward area for the month and we saw examples that included the noise disturbance at night.
- Effective patient safety systems, processes and standard operating procedures were seen in place across this service for example patients at risk of falls and falls prevention.
- Staff assessed patients for an infection such as sepsis, where an infection was identified treatment was commenced in a timely manner.
- Safeguarding vulnerable adults, children and young people was given priority. Staff were appropriately trained, proactive in their approach to safeguarding and were focussed on early identification.

However;

- Safety thermometer data not displayed in all areas we visited and therefore trends in safety incidents were not visible for patients and relatives to see.
- Staff raised concerns about the obstruction created by six clinical waste trolley bins. Staff told us that the waste bins were permanently situated outside the theatre area, which prevented thorough cleaning.
- Records were accurate, but we saw illegible signatures with no job title or date of entry.
- Observations and intentional rounding entries contained illegible signatures.
- Records were stored in unlocked trolleys; however, staff told us that new locked trolleys were being delivered to those wards that currently did not have them.
- Although arrangements were in place to ensure the safe administration and storage of medicines, one area out

of five visited did not record the minimum, current and maximum temperature of the medicine fridges we therefore could not be assured that medicines were stored appropriately within this area.

Incidents

- Between August 2015 and July 2016 the trust reported three never events for surgery. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- We discussed two never events with the service during our inspection. One involved a missing screw on a piece of equipment used in surgery and the other was a small pin missing. Both patients were x- rayed and thoroughly reviewed with no patient harm in either case. A root cause analysis (RCA) was used to investigate the never events. An RCA is a method used to identify the causes or problems associated with the never event or serious incident. We saw action had been taken when the root cause had been identified for example a new checking procedure of equipment was now in place in theatre. We observed this to be the case during our inspection.
- There were 12 serious incidents reported by the surgical division across the trust between August 2015 and July 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response (NHS England, March 2015). The most common type of incident reported was pressure ulcer (seven incidents).
- Between July 2015 and June 2016, there were 202 incidents reported in surgical areas at this hospital. Low or no harm incidents accounted for 92% (187) of the incidents. There were 6.9% (14) moderate incidents, one near miss was recorded. A near miss is an unplanned event, which did not result in injury, illness, or damage, but had the potential to do so.
- Staff recognised concerns, incidents or near misses and confirmed how they reported these. Where incidents had been reported staff said they received feedback and gave examples of where learning from incidents had taken place. For example following a patient fall the trust had introduced slip less slipper socks.
- We saw learning shared across the service through departmental meetings, emailed news updates and shift handovers.
- We saw the ward health dashboard checks incorporated the medicine incidents but not the total incidents recorded for the service. Theatre staff informed us that if a patient had a missing identity band they completed an incident report which was fed back to the ward area where the patient was admitted but that incident was still included within the theatre numbers.
- Mortality and morbidity discussions were held monthly. These meetings are used to review deaths within the service and to learn from them. We reviewed minutes between June and August 2016 and saw where patient deaths and treatment complications had been discussed. We saw seven action points had been identified to improve patient safety and support professional learning. The action log created ensured that all actions were followed up and completely within an agreed timeframe.
- The trust wide mortality review assurance group (MoRaG) held monthly meetings and reviewed all mortality and morbidity which included any further actions.
- Staff were aware of and understood the Duty of Candour process. Staff had prompt cards to support them. 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 service users (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. As soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Staff were aware of and appeared to understand the trust duty of candour policy. The serious incident investigation training included duty of candour. Staff spoke about telling people when an incident or near miss had occurred. We reviewed divisional meetings minuted which contained duty of candour recommendations following complaints.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and

analysing patient harms and 'harm free' care. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter, and blood clots or venous thromboembolism (VTE).We saw for the three month period May to July 2016 across the five surgical wards there were seven patients who experienced harm through falls, pressure ulcer and urinary tract infection.

- Between May and July 2016 of the 102 patients admitted to surgical services on average 5% obtained pressure ulcers, 1.6% had a fall resulting in harm, 0.86% obtained a catheter and new urinary tract infection (CAUTI) and 1.2% a venous thromboembolisms (VTE).
- Compared to national averages the service was under-performing in the areas of harm free care, pressure ulcers, falls with harm and catheters and CAUTI's.
- The safety thermometer was not displayed in all areas which meant patients were not informed of the latest outcomes for quality of care.
- Junior nursing staff and doctors were aware of the importance of completing VTE and their responsibilities.
- We saw general surgery and trauma and orthopaedics governance and performance meeting minutes from May 2016 had raised the importance of prescribing and administration of the correct treatment to reduce the risks of VTE.
- We reviewed the documentation of four patients with pressure ulcers. We were not assured that the grading for one patient was appropriate. We saw that a grade four pressure ulcer was initially documented as grade two by the tissue viability team. We escalated this to senior nursing staff who confirmed that they would review this case.

Cleanliness, infection control and hygiene

- The wards and theatre areas inspected were visibly clean, well-organised and uncluttered. Two ward areas were in need of repair and refurbishment. These wards were on the risk register. Worn hazard tape was seen on the floors in the main corridor areas. This meant that there was a risk of infection due to the inability of cleaning within this area.
- We saw large covered clinical waste trolley bins positioned along the main theatre corridor. This meant it would be difficult to thoroughly clean this area.
- We were assured that cleanliness, infection prevention and control (IPC) and hygiene had been given priority. Between September 2015 and August 2016, we saw environmental cleaning audit results were consistently at or above the trust target of 95% for each month.
- Pilgrim hospital participated in the patient led assessments of the care environment (PLACE). PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both NHS and independent healthcare sectors in England. The PLACE results for May 2016 showed a cleanliness score of 93%, this was an improvement on the 2015 score (90%) but remained below the England average at 98%.
- Between February 2016 and March 2016 there had been a norovirus outbreak across the hospital. No surgical wards were closed as patients were isolated. This meant that the service had an effective system in place to minimise the risk of spreading infection.
- Between October 2015 and August 2016, there were no healthcare acquired cases of meticillin resistant staphylococcus aureus (MRSA, which is usually spread through skin-to-skin contact).
- In the same period there were five cases of meticillin sensitive staphylococcus aureus (MSSA, a serious infection that can cause blood poisoning) and six avoidable cases of Clostridium difficile(a bowel infection that can cause diarrhoea). The trust target was to ensure that there were less than 59 cases.
- We observed staff completing good hand hygiene practices, wearing appropriate personal protective equipment such as gloves and aprons
- We observed staff complying with bare below the elbow policy across the services visited.
- There were hand cleansing gel dispensers on entry to all areas and also at the point of care. Appropriate signage regarding hand washing for staff and visitors was on display and we observed staff using the cleansing gel.
- The trust carried out an audit which looked at the five moments for hand hygiene. Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients.
- Between October 2015 and August 2016 the service achieved 59% compliance in the hand hygiene audits.

This was due to the service on 22 occasions not returning the required submissions. We also observed that no returns were included from theatres for the same period.

- The service had recognised the shortfall and had instigated hand hygiene awareness initiatives that included drop in and roadshow sessions trust wide, four monthly hand hygiene awareness weeks and the use of online training videos.
- Equipment had 'I am clean' stickers on them. These were visible and documented the last date and time they had been cleaned. This meant staff knew the equipment was clean and ready for use.
- Curtains around bed spaces were disposable. The curtains were dated with dates when they had first been put up and were replaced when contaminated or after four months. We did not find any issues or concerns with curtains being replaced.
- There were systems in place for the management and disposal of clinical waste and sharps in accordance with the trust policy for all ward areas.
- Surgical site infection monitoring is mandatory for all trusts although not all categories of surgery are required to be included. Surgical site infection rates were reported for hip and knee replacements and showed that there were no reported infections between January and June 2016.
- With the exception of Bostonian Ward, there were a limited number of side rooms across the surgical wards. We saw appropriate patient isolation used across the surgical wards. Staff wore personal protective equipment and disposed of that equipment appropriately during the inspection.
- All patients were screened pre-operatively for MRSA or as soon as admitted if an emergency in line with local policy and national guidance.

Environment and equipment

- All ward areas were clearly sign posted with entry buzzer accessed areas. There was secure entry to the theatre department.
- We observed that one ward area (3a) was not calm and uncluttered during the inspection due to the high volume of pre-operative patients admitted in an already busy ward area.
- Resuscitation and emergency equipment for adults was available in all areas and in the theatre area. Staff were aware of their location in the event of an emergency.
- Our review of resuscitation equipment across all areas confirmed this had been checked in line with trust policy.
- The adult resuscitation trolley and anaesthetic machine in theatre had been checked daily was in line with the trust policy.
- A difficult airway trolley containing emergency intubation equipment was available in theatres. Intubation is the placement of a flexible plastic tube into the windpipe to maintain an open airway. We reviewed the difficult airway trolley which had daily checks completed in line with trust policy.
- The risk register identified a lack of electrical sockets in each bed space on ward 3a which meant that some patients requiring additional electrical equipment might need to be moved to accommodate their safe care and well-being.
- There were no emergency call bells on the third or fifth floor ward areas; an option appraisal was about to be undertaken for this work.Currently other patients use their call bells in the absence of an emergency call bell which could pose a risk to patient safety.
- Staff were aware of the process for reporting faulty equipment; we saw appropriately labelled equipment waiting for repair in a utility room.
- All equipment in use had clear safety test and pre-planned maintenance labels to demonstrate compliance.
- Staff were trained before using equipment but incomplete competencies folders were seen on one ward. The ward sister confirmed she was currently reviewing the records which were not held electronically.
- We saw staff using specialist equipment to care for a bariatric patient during our inspection. Staff confirmed that if they required additional bariatric equipment for patients with an increased body weight, it was easily available through the manual handling team. Equipment alarms on infusion pumps were checked and set appropriately for each patient. Although some patient's had feedback that the equipment alarms disturbed them at night as the volume level were more pronounced during the "quieter" night hours.

Medicines

- Medication charts for eight patients were reviewed and found to be complete, up to date, and reviewed on a regular basis by the pharmacist.

- We looked at the medicine administration records for eight patients across two wards. We saw appropriate arrangements were in place for clearly recording the administration of medicines. Records showed people were getting their medicines when they needed them. If people were allergic to any medicines this was recorded on their chart.
- Where antibiotics were prescribed indications and durations of treatment were recorded appropriately. A microbial stewardship review was completed to ensure that antibiotic usage was appropriate and completed in line with the full course prescribed. We spoke to five patients who all told us they received information about their medicines whilst on the wards and in preparation for discharge home.
- Controlled medicines, (these are medicines controlled under the Misuse of Drugs regulations 2001 and have set requirements for how they are stored, supplied and prescribed). Medicines on the wards and in theatres were stored appropriately and drug records were accurately completed. Emergency medicines were available for use and these were in date and replaced by pharmacy when used.
- Central medicines in theatres and anaesthetics were secured with access only through the departmental lead. We saw no medicines drawn up pre-anaesthetic and left unattended.
- Discharge medications to take out (TTOs) were reviewed during the inspection; there were no delay or concerns seen.
- Three staff described accessing the correct TTOs medicines as a problem although the use of over labelled pre-packs had improved the situation. Problems arose when there were discrepancies between the medicines chart and the expected date of discharge (EDD) which resulted in the medicines produced for discharge by pharmacy (from the medicines administration chart) being incorrect.
- Staffs were seen completing medication rounds wearing red “Do not disturb" tabards. However, during our visit to ward 3b we saw staff being disturbed by others during the medication round, this increased the risk of a medicines error occurring.
- A pharmacist and technicians visited all wards each weekday in either the morning or afternoon with on-call support out of hours. We saw that pharmacy staff checked that the medicines patients’ were taking when they were admitted were correct and that records were up to date. Medicine interventions by a pharmacist were recorded on the paper charts to help guide staff in the safe administration of medicines. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.
- Medicines, including intravenous (IV) fluids were stored securely and managed appropriately. On 3b ward, we did not see records to assure us that refrigerated medicines were stored at the correct temperatures to ensure they would be fit for use. The method of temperature recording was not in line with the Trust’s policy which we brought to the attention of the ward sister who agreed to review future recordings. Limited shelf life products did not display date of opening or new expiry dates meaning that staff could not be assured these medicines remained safe and effective to use. Staffs were confident in reporting medication errors and a consistent approach to reporting and sharing incidents was described at handover or ward team meetings.

Records

- We reviewed eight sets of patient care records that were dated and signed with clear plans of care. All records were multidisciplinary and we saw where nurses, doctors and allied health professionals including physiotherapists had made entries; for example, falls and pressure damage were assessed, monitored and managed on a daily basis using nationally recognised risk assessment tools incorporated into care plans.
- We saw no ink stamps in use for doctors on the wards to provide them with a clear name and general medical council number (GMC) to meet the guidance from the GMC. There were two illegible signatures with no GMC number or job title in the records reviewed. We were informed that all new doctors within the trust were issued with ink stamps.
- Staff stored medical records securely in restricted areas or in lockable trolleys in clinical areas in line with data protection policies.
- A flagging system used on the bed management system which identified those patients at risk of falls or nutritional assessment but on drilling down into the system found the data was not used across the MDT or updated completely with six patients reviewed

- All records were paper based and we saw that records were not always organised or tidy, with up to date test results filed within them. We saw organised by date notes being completed by the ward clerks across the division during the inspection.
- Patient scans, blood tests and pharmacy documentation were seen as hard copies within the paper records.

Safeguarding

- The executive lead for safeguarding was the director of nursing who was supported by the deputy chief nurse. There was a named professional for safeguarding adults who was supported by a safeguarding practitioner.
- The trust set a mandatory target of 95% for completion of safeguarding training.
- Safeguarding training data for September 2016 showed 96% of nursing and medical staff were in date with safeguarding children level one safeguarding children level two compliance was 83%. Safeguarding training compliance for adult's level one was 96% and level two 79%. Data submitted was not separated for medical staff.
- Staff knew about the trust's safeguarding process and were clear about their responsibilities. Staff involved with safeguarding incidents felt supported and knew who to contact for further advice and support.
- Display boards around the ward areas gave comprehensive information on safeguarding including deprivation of liberty and the Mental Capacity Act (2005) information. Contact numbers were visible to staff for further support.
- Female genital mutilation (FGM) is defined as the partial or total removal of the female external genitalia for non-medical reasons. Nursing and medical staff spoken with confirmed that they had received FGM training which was included as part of mandatory training.

Mandatory training

- Mandatory training included moving and handling, infection prevention and control, equality and diversity, information governance, conflict resolution, basic life support and safeguarding vulnerable adults and children. Mandatory training was accessed either through an electronic learning tool or attendance in the classroom. Some staff said it was difficult to attend if the ward was busy or short staffed.
- The ward managers confirmed that they included staff rostered for training onto the electronic rota to ensure that time was protected while meeting the ward requirements.
- Mandatory training data provided by the trust demonstrated that across this service on 30 Sept 2016, nursing and healthcare support workers compliance was 87% and medical staff compliance was 81%, both below the trust target of 95%.
- The annual Basic Life Support (BLS) resuscitation training showed 49% compliance for nursing and healthcare support workers and medical staff within this service compliance was 35% both which did not meet the trust target of 95%.Senior staff confirmed priority training dates for staff to attend.
- Newly appointed staff completed the trust induction programme. Newly qualified registered nurses completed a trust induction and a preceptorship programme.

Assessing and responding to patient risk

- The service ensured risk based pre-operative assessments were carried out in line with guidance on pre-operative assessment for day and inpatient cases.
- The service ensured that there was access to consultant surgeons through the on call system which allocated a named consultant with overall responsibility for the service.
- There was access to interventional radiology and therapeutic endoscopy (a diagnostic test performed using a camera within a thin scope) between Monday and Saturday with the facilities to provide 24 hour cover seven days a week but there was no out of hours laboratory or radiologist support.
- Safety quality dashboards were seen on wards except for the day ward, which gave information for falls; do not attempt cardio pulmonary resuscitation (DNACPR), sepsis compliance, tissue viability, nutrition, medication, venous thromboembolism, urinary catheter, peripheral catheter and dementia review. All patients over 65 were screened for dementia.
- A National Early Warning System (NEWS) was used for all patients across the hospital to assist staff in the early recognition of a deteriorating patient. Staff recorded routine physiological observations such as blood pressure, temperature, and heart rate to assess whether a patient's condition was deteriorating and there was evidence of continuation of monitoring and treatment.

Surgery

- We reviewed eight patient observation charts and all NEWS were completed and calculated correctly and escalated appropriately in line with the trust escalation of NEWS monitoring in adult patients.
- Patients with a suspected infection or NEWS of five or more were to be screened for sepsis using a 'Sepsis Identification Checklist" and care bundle. Sepsis is a severe infection that spreads in the bloodstream; patients being treated for sepsis were 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 treatment that is much more extensive and has been shown to be associated with significant mortality reductions when applied within the first hour. Sepsis six bundles commenced for patients with a raised temperature and respirations.
- One patient record showed antibiotic therapy had commenced after blood cultures but was not written up according to trust guidelines with a once a day dosage when it should have been twice daily. The pharmacist did not change this on the review twenty-four hours after escalation to senior staff, which had not affected the patient at the time of review but may have further consequences.
- The trust had a sepsis overview action plan for 2016/17. This was produced in response to a sepsis review in 2015 following being identified as an outlier with more patients dying from sepsis than expected between December 2014-2015. An outlier is when results are below the expected range against the England average. This included the launch of a sepsis bundle in April 2016, providing clear guidance on the detection and treatment of suspected sepsis and an e-learning package for all front line staff. Sepsis screening measures include patients who received intravenous antibiotic therapy within one hour of sepsis the trust target is 50% but the trust result showed 38% compliance between April and August 2016
- The visual infusion phlebitis (VIP) score was not completed on admission for two patient records reviewed within this service. VIP is a tool for monitoring infusion sites on patients to detect early signs of infection.
- Venous thromboembolism (VTE) assessments were completed for all patients on admission to the hospital and reassessed as required.
- Clinical staff followed the nationally recognised five steps to safer surgery checklist. Staff used a document based on the World Health Organisation (WHO) safety procedures to ensure each stage of the patient journey from ward through anaesthetic procedures, operating room and recovery was managed safely.
- We observed the Five Steps to Safer Surgery process from the sign in to the sign-out as the patient left theatre. We saw this was fully completed.
- The theatre team had completed a random sample of 100 patients to review compliance with the documentation. The audit was submitted to the clinical governance department and the results were developed into a WHO checklist dashboard which was reported to the trust board each month.
- We saw an overall compliance of 98% against the 100% target between July 2015 and June 2016. The failure to complete the sign out of theatre section was the main cause of non-compliance. This was observed as now being completed by the recovery team as part of the handover.
- The multidisciplinary team assessed patients prior to admission. This allowed staff to highlight patients' care needs before surgery and have plans in place following surgery.
- Patient falls were minimised within the wards by the use of "slip less" sock slippers. These were used if the patient falls risk assessment showed that the patient was at risk.
- Patients were pre assessed and screened to ensure that they were suitable for surgery before their admission for surgery.
- We saw eight patients assessed on admission in line with anaesthetic services assessment and a consultant anaesthetist or consultant surgeon review for those patients who required emergency surgery irrespective of the time of day or night or the predicted mortality.
- Consultant's informed us that their rosters consisted of four shifts for general surgery followed by three shifts off.
- At discharge patients were given the contact details of the ward and details if required for specialist staff to call in case of emergency following discharge.

Nursing staffing

Surgery

- The departments were managed by the ward managers and matron. Most areas appeared calm and risks to patients were minimal including those times where it had been identified the ward had below safer staffing levels and bank or agency staff filled those staffing gaps. On the unannounced visit, the ward manager was seen caring for patients within her ward area instead of completing a manager's day to cover for staff sickness.
- Staff data was collected by the nationally recognised 'Safer Nursing Care Tool' and patient acuity and dependency audit tool in conjunction with professional judgement principles. These comprised of nurse to patient ratios as suggested by National Institute of Clinical Excellence (NICE) guidance of one registered nurse to a maximum of eight patients. Acuity is the level of the condition of a patient.
- There were tools in place to collect patient acuity and dependency data; the Trust used this to determine safe staffing establishments for each area. On a daily basis matrons and senior nursing teams reviewed patients and considered staffing and skill needs throughout the day.
- The data was considered alongside staffing information from the nursing staff electronic rostering system and patient information including admissions and discharges.
- The staff roster was reviewed for four weeks either side of this inspection across theatres and the five surgical wards, which showed staff, had worked extra hours due to staff vacancies or sick leave.
- We discussed vacancies for each of the areas we visited with senior staff. Senior staff told us that vacancies were addressed and recruited into. The process could take up to three months from staff leaving until the point of staff appointed on the ward. Staff on ward 5a told us there were nine registered nurse vacancies and on 5b ward they had six whole time equivalent registered nurse vacancies.
- The total staffing vacancies across the surgical division between April and August 2016 were; registered nurse vacancies 27.79 whole time equivalent (wte) and 8.07 wte for non-registered staff.
- The regular use of bank and agency was seen and some agency staff were part of the team with regular bookings to promote continuity of care. From April 2015 to March 2016 the nursing bank and agency usage was 10.95% across surgery.
- There were arrangements in place for the induction of bank and agency staff who had not previously worked in surgery, which included a checklist to be completed once an induction had taken place. We observed this during our inspection and were told there were no dedicated night staff as all staff rotate to promote development opportunities.
- Handovers were seen during the inspection which were comprehensive and allowed the staff to have a complete patient update.
- Each ward had a safe staffing board at its entrance which displayed planned and actual staffing numbers.
- The number of actual staff on the ward and the confirmed staff establishment seen during the inspection confirmed that all shifts were covered. We were aware that extra bank or agency registered staff were used to cover the wards.
- Skill mix and staff morale in theatres was managed well with staff rota's displayed eight weeks in advance and training dates displayed outside the manager's office.
- The nursing staff average turnover rate in this service was 7.61% for June 2016, against the trust wide average of 8.54%. Staff turnover refers to the number or percentage of workers who have left an organisation and been replaced by new employees.
- Senior staff worked two clinical shifts a week but informed us they were included in the ward staffing numbers.

Surgical staffing

- The trust had a lower number of consultants (40%) and middle grade doctors and registrars (39%) than the national average (88%). Junior grades at 21% were higher than the national average of 11%. The surgical and orthopaedic teams covered the service with out of hours covered by on call rostered teams. There was a roster for consultant cover for the week but we were unable to confirm that they were freed from other duties.
- Medical staff completed morning and afternoon or early evening ward rounds to meet the needs of the patient. We saw an early morning and late afternoon ward round with different grades of staff present.
- The junior doctors provided daytime cover across all the surgical speciality wards and we saw a new admission to ward 3a seen within 30 minutes of admission. Staff confirmed they were able to access staff with no difficulty.

- There was a registrar middle grade rota providing 24 hour cover seven days a week for the wards.
- Out of Hours cover (weekend and nights) was provided by an on call rota.
- Comprehensive staff handovers were seen with the patient handover printed out as hard copy. A junior doctor confirmed she completed her medical staff handover as a separate word document which was different to the nursing staff handover sheet.
- Locum use was low From April 2015 to March 2016 this service reported a bank and locum usage rate of 10.9% which was low as medical staff confirmed appointments were difficult to attract to this area.
- Registrars confirmed that they had no problem contacting the consultants out of hours or during the working week and felt supported.
- Surgical staff told us that the work pattern, for example early morning starts to theatre lists and theatre lists ending late was not sustainable. Consultant's rotas were four shifts for general surgery and three off.
- A medical consultant was available on-call and could be contacted and available within 30 minutes if required.

Major incident awareness and training

- The major incident plan was updated in July 2016 in line with other neighbouring services such as the local ambulance service.
- Staff were unaware of the major incident and business continuity plans and their responsibilities within these; however staff said they would follow instructions given by the senior team. Staff confirmed they had not been involved in any recent major incident exercise.

Are surgery services effective?

Good

We rated effective as good because:

- Patient's care and treatment was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to the National Institute for Health and Care Excellence (NICE) quality standards. For example, enhanced recovery protocols were in place for colorectal and vascular surgery.
- There was effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment.
- Staff were qualified and had the skills they needed to carry out their roles effectively.
- Staff had a good understanding of the relevant consent and decision making requirements in line with legislation and best practice guidance.

However:

- We saw delays with administration for pain management with no observed referrals to the pain management team during the inspection.
- Three patients told us that pain was not always managed in a timely way.
- The trust results in the National Emergency Laparotomy Audit showed out of 11 measures only two areas were compliant with eight measures amber and one red.

Evidence-based care and treatment

- There was an enhanced recovery programme for hip, knee, colorectal and vascular specialities in line with the NHS Institute for Innovation and Improvement. The aim of the enhanced recovery programme is to improve patient outcomes by reducing the recovery process, benefitting both patients and staff. Information was provided to patients regarding pre assessment, preparation before surgery and daily programme for recovery and post discharge.
- Theatres were complaint with best practice guidance for difficult airway management. For example there was a dedicated difficult intubation trolley in theatres. Intubation is the placement of a flexible plastic tube into the windpipe to maintain an open airway.
- Policies used were based on National Institute for Health and Clinical Excellence (NICE) and Royal College's guidance and work had been completed by senior staff on providing standards for the national benchmark group for example following the care of a patient who had general surgery. All guidance were reviewed by the clinical business unit (CBUs) and circulated to clinical leads to advice on relevance to clinical specialities and compliance.
- We reviewed six clinical guidelines. These were all easily accessible, in date, current and version controlled guidance from for example; NICE, Royal College of Surgeons or equivalent. Policies and guidance seen included, carotid endartectomy (removal of the inner

lining of the neck artery), care of Hickman's lines and outbreak management. Staff provided care to patients based on national guidance and showed awareness of recent changes in guidance and we saw evidence of discussion based on these guidelines, for example, the service used the early warning score to alert staff should a patient's condition deteriorate.

- Emergency theatres followed guidance published by National Confidential Enquiry into Patient Outcome and Death (NCEPOD). For example patients who required emergency surgery after 10pm, were recovered in theatre and then returned to a surgical ward.
- The National Early Warning Score (NEWS) system was in place across the surgical areas to monitor acutely ill patients in accordance with NICE CG50 and CG83.
- We saw systems in place to provide care in line with best practice guidelines (NICE CG50 Acutely ill patients: Recognition of and response to acute illness in adults in hospital).
- The surgical services adhered to the NICE guidelines for the treatment of patients which was assessed by the surgical governance process to ensure the service was compliant.
- The policies were used to develop how services, care and treatment were delivered. This included guidance such as NICE and Royal College of Surgeons (RCS). Policies were referenced in accordance with the hospital clinical governance policy. Policies were available on the intranet and staff demonstrated how they gained access to them.
- VTE assessments recorded were clear and evidence based, ensuring best practice in assessment and prevention.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and national guidelines, including RCS standards for emergency surgery.
- The pre-operative assessment clinic assessed and tested patients in accordance with NICE guidance for someone due to have a planned (elective) surgical operation. Examples included MRSA testing.
- Completion of the 'five steps to safer surgery' checklist, designed to prevent avoidable harm was audited and findings shared with the appropriate teams. The WHO safer surgery checklist audit between April 2016 and Sept 2016 showed they had looked at a sample of 100 patients. The overall compliance for the checklist was 98%. The audit identified the areas of non-compliance which included the failure of signing the patient out of theatre section. Actions were seen already taken by the service with the recovery team including this check as part of the handover of the patient to ensure compliance.
- Staff confirmed audit feedback was given at monthly meetings and we saw results graphs displayed in theatre.
- Staff used integrated care pathways for surgical procedures such as, hip or knee replacement. Staff in the ward and theatres used enhanced care and recovery pathways, in line with national guidance. Patients' needs were assessed using clinical pathways which were evidence based and used recognised risk assessments.
- We reviewed four records and found the NEWS chart had been completed in full on all the records viewed. Senior staff confirmed they had undertaken additional training with staff to highlight the importance of managing the deterioration of a patient correctly. Staff confirmed this had been highlighted during a staff huddle.

Pain relief

- The hospital fully complied with all of the standards set out by the Faculty of Pain Medicines Core Standards for Pain Management (2015). For example, there were standardised assessment tools and clear protocols for the management of acute pain by ward staff.
- The hospital had a pain management service available for advice and support. The dedicated acute pain team was led by a consultant and lead nurse with three registered nurses who delivered a five day a week service. Staff confirmed they knew how to access the team but we did not observe access during this inspection.
- We saw a pain management nurse with a patient following his operation and heard the patient feeding back to the nurse in a positive manner.
- Ward staff told us they felt supported by the pain team and anaesthetists
- Pain relief was administered dependent on the best method for the patient which could be through oral tablets, injection or patient controlled analgesia. A

patient controlled analgesia (PCA) intravenous pump delivered a measured dose of analgesia on patient demand. Staff recorded observations hourly while PCA was in use to ensure close monitoring of the patient.

- Four records reviewed demonstrated that pain relief assessments had been completed pre-operatively and patient pain scores were calculated, documented and appropriate pain relief was provided to the patients. However, we saw one patient two days following surgery and the records showed gaps in the pain management score. The score on day one after hip replacement was nil. This was raised as a concern with senior staff as the patient confirmed they had pain on day two. .
- Two out of eight patients confirmed that they had to wait for more than 30 minutes to receive pain relief due to staff being busy with other patients.

Nutrition and hydration

- Staff completed malnutrition universal screening tool (MUST) on all patients admitted to surgery. The MUST is a five-step screening tool to identify adults at risk of malnutrition. All records reviewed had completed MUST screening assessments.
- Patients who required general anaesthetic were required to fast before surgery and patients were informed of the cut off time for drinking clear fluids. This meant that patients were not fasted for extended periods of time prior to surgery. The surgery and anaesthetic team reviewed the theatre list order at the beginning of the day to ensure that patients had clear fluids only until the allocated time agreed.
- Patients were kept nil by mouth for the least time possible. We saw there were protocols in place to ensure patients received adequate nutrition and hydration for example we saw intravenous fluids and other feeding included percutaneous endoscopic gastrostomy (feeding through a tube in the stomach) and total parental nutrition (TPN) supplemented as prescribed.TPN is a method of feeding that bypasses the gastrointestinal tract.
- Staff told us that there was easy access to the dietitian and we saw the dietitian completing a review of patients within this service.
- Protected mealtimes were advertised on the ward board but we saw staff from the multi-disciplinary teams (MDT) going to patients unchallenged during that time. For example; a patient was with the physiotherapist at mealtime but staff confirmed they had kept their food hot until they were ready.
- Staff gave patients sips of water to establish if they could swallow effectively following surgery. Assessment by a speech and language specialist team (SALT) could be requested if they were concerned about a patient's ability to swallow.
- Post-operative nausea and vomiting medications (PONV) were not seen prescribed routinely which meant there could be a delay in the treatment of PONV.

Patient outcomes

- There was an audit plan and tracker for surgery. Audit activity included national and local audits such as cannula care, safer surgery and consent. We saw following audit action plans were in place to address any shortfalls. Audit results were shared through performance meetings that were held monthly in addition to audit meetings.
- Anaesthetic provision followed the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists guidance. Participation in the Anaesthesia Clinical Services Accreditation Scheme (ACSA) was not an essential requirement and the trust had not applied to join this voluntary quality improvement scheme for NHS and independent sector organisations.
- The enhanced recovery programme was established to support patients with a faster recovery period following surgery.
- In the 2016, National Emergency Laparotomy Audit (NELA) Pilgrim hospital achieved a rating of 70-100% for one measure, 50-69% for eight measures and below 49% for one measure which was comparable to previous data. In the 2014 NELA, 12 of 28 services were found to be available. Pre-operation input was available on request, post-operation input was available on request, and peri-operative input was available on request.
- In the national bowel cancer audit 2015, 79% of patients undergoing a major resection (larger part of bowel removed) had a post-operative stay of greater than five days. While the trust had improved the percentage this was just lower than the England average of 80%.
- In the 2016 hip fracture audit the risk adjusted 30 day mortality rate was 7.42% which was within national expectations. The proportion of patients having surgery

on the day or the day after admission was 89%, this met the national standard and showed improvement on the 2015 hip fracture audit results of 85%. The peri-operative medical assessment rate was 98% which did not meet the national standard of 100%.The proportion of patients not developing pressure ulcers was 95.8% which was better than most trusts across England.

- Between Januarys to June 2016 the hospital length of stay had increased for the 318 patients reviewed, with an increased length of stay of 17.5 days. This had increased from the 2015 audit results of 13.8 days but remained lower than the England average of 20 days.
- Between April 2015 and March 2016 the trust met all of the indicators in the patient reported outcome measures (PROM) for groin hernia repair, hip replacement, knee replacement and varicose vein surgery. This was in line with the England average.
- All patients with fractured neck of femur were admitted and received treatment within 36 hours as set out in the national guidance. A business case had recently been approved which increased theatre capacity within general surgery and had reduced the theatre backlog in this area.
- In the 2015 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was poor quality data. The 2014 proportion was not reported. The 90 day post-operative mortality rate was not reported. The 2014 rate was 13.5%. The proportion of patients treated with curative intent in the Strategic Clinical Network was 42.5% which was; significantly higher than the national aggregate.
- The surgical service had a theatre delivery plan which included the development of a safe and effective means of capturing proposed surgical procedures to enable the accuracy of patient records, referral to treatment time tracking and coding.
- To implement a pre-operative assessment service that met best practice and supported the delivery of increased theatre list utilisation.

Competent staff

- All new staff attend an induction programme which included mandatory training. New staff confirmed that they had attended a corporate and local induction which prepared them for working within this service.
- A preceptorship package (a programme of supervision with a specialist) was available for all newly registered nurses and senior staff confirmed that study days were also provided for new staff
- Staff felt supported by their line managers, although they had no formal supervision sessions they felt the support they received was sufficient.
- The staff survey showed that some staff across the trust were not receiving appraisals or supervision. Staff told us that over the last year line management had improved and they are now either up to date with their appraisals or a date had been set within the next few weeks. We spoke to managers who confirmed there was a rolling programme for appraisals.
- Staff told us they received annual appraisals although one member of staff confirmed their last appraisal was in 2014. Staff told us objectives set at their appraisal were meaningful, achievable and reflected the trust values. Appraisal rates were variable across the trust due to gaps in staffing and reduced levels of compliance since 2015.
- Information provided by the trust showed appraisals figures for July 2016 were 69% lower than the same period in July 2015 when compliance was 78%. Theatres confirmed their compliance had dropped due to new starters who were enrolled on the preceptorship programme. The trust target rate is 95%.
- Medical staff appraisal showed on 31 March 2016 84% compliance trust wide with consultants 93% and other staff grade, associate specialist and doctor's compliance was 76% which was entered on the electronic appraisal system to support revalidation.
- There were inconsistencies within the staff educational folders. For example, some staff had competency updates within their folders whilst other new staff personal folders were found empty and the ward sister informed us these were being reviewed. We were told there were no competencies held electronically.
- Theatres had a dedicated educational training coordinator and the wards had a clinical educator who was also the deputy ward sister.
- Registered staff were supported to maintain their professional development for revalidation with professional bodies through training, reflective practice and education. Staff were being offered individual assistance with their revalidation requirements. Information related to nurse revalidation was in the staff rest room.

- Development opportunities were in place to support band 6 staff working towards their band seven positions but staff told us that they had increased demands on them due to sickness and maternity leave.
- Healthcare support workers were trained to work alongside members of staff supporting each other in performing and documenting observations.
- Each ward kept a record of the staff competencies as paper copies we were told they were not on any electronic system.
- Training and development was discussed at staff meetings and staff were attending a national conference later this year.
- Junior and trainee doctors told us they had appropriate practical training opportunities and good supervision.

Multidisciplinary working

- There were weekly multidisciplinary team (MDT) meetings with representation from radiologists, surgical team, oncologists and nurse specialists. Newly diagnosed patients, post-operative patients and onward referral of patients were discussed to ensure continuity and consistency of care.
- White boards were in use on all surgery wards to indicate which patient required specialist input and were updated twice daily following ward rounds.
- There were a daily MDT ward round with input from all professionals. Some formal MDT meetings took place across all hospitals sites to meet the patient's best interests and needs for future continued care for example with complex requirements needs.
- Staff reported that MDT working within the department was efficient and effective. We saw minutes of meetings that reinforced this.
- Doctors (foundation year two) confirmed they were on call once or twice a month and were well supported by the registrar and consultant team.
- Two ward rounds were seen being completed in the morning and late afternoon with the medical, nursing staff and the dietician present. This ensured that the patient's needs were met as the patient's care was reviewed.
- The service ensured that access to consultants were available when needed through the roster and on call rota.
- A medical consultant was available on-call and could be contacted and available within 30 minutes if required.
- The service met the objectives introduced following the Francis report with the release from the Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients (June 2014) which was implemented by each patient having care under a named clinician and that a named nurse is identified for each patient to improve quality of care. Those names were seen on above the patient's bed and in the patient's care plan.
- Patients were admitted under the care of a consultant who has overall responsibility for each individual's care.
- The physiotherapists and occupational therapists supported patients after surgery and for assessments prior to discharge home.
- Oncology services held a weekly MDT meeting. This was held using conference facilities to cover the whole trust and neighbouring trusts involved in the patient's care.
- Electronic discharge summaries of care were sent from hospital to the GP in the community.
- In theatres, the MDT held a daily meeting to review all patients on that day's list.
- Effective communication between teams was in place. The surgical wards were mixed speciality wards divided into elective and emergency admissions with orthopaedic patients alongside general surgery patients which meant the medical teams were responsive to supporting the nursing staff.

Seven-day services

- Theatre staff were available seven days a week and an on call rota was in place for surgical and anaesthetic teams.
- Physiotherapy and occupational therapy services were available seven days a week; there was an on call, out of hour's service.
- Diagnostics services were provided seven days a week which included endoscopy, computerised tomography (CT) or magnetic resonance imaging (MRI) scans. A CT scan is a three dimensional X-ray. MRI is a scan which uses radio waves to create detailed images of the organs and tissues within the body. Senior staff told us that they were able to get emergency diagnostics services and pathology tests out of hours and at the weekend.
- Interventional radiology was available with the facilities to provide 24 hour cover seven days a week but there was no out of hours laboratory or radiologist support available.

- The 'hospital at night' team of nurses and clinical support workers provided additional acute care delivery such as cannulation and the taking of blood samples.
- Pharmacy was available between Monday and Friday 9am to 5pm with a reduced Saturday service 9 am to midday. The out-of-hours service was provided by the on call pharmacy team for urgent advice and medications. An out of hour's emergency medication store was accessed through the operational site team.
- There was medical and anaesthetic support out of hours as well as on call managers for the division.
- Staff confirmed that the consultant was present for daily wards rounds including the weekend to assess any patients that they had concerns about. They were able to easily contact the consultant as needed for support, this included contact out of hours.
- Microbiology and infection prevention and control were available Monday to Friday 0800-1600 with consultant cover through an on call rota. During any infectious outbreaks, (more than three people with the same infectious illness) cover was provided by the infection prevention and control nurses on an on call rota to meet the needs of that group of patients.
- Consultants and anaesthetists were either resident or on-call 24 hours a day, seven days a week.
- Vascular surgery had a 24 hour seven day a week service supported by interventional radiology.
- A mental health liaison team was available 24 hours a day, seven days per week.

Access to information

- Staff did not report any problems with access to patient information and we saw in theatres a "live" electronic communication system being used.This allowed staff to manage patients throughout theatres and theatre schedules.
- When patients move between teams and services, including at referral, discharge, transfer and transition, the information needed for their ongoing care shared is available and in line with relevant protocols. Information to support the care and treatment of patients was readily available and staff raised no concerns about information not being available.
- We saw electronic systems that manage information about patients that supported staff to deliver effective care and treatment. Concerns were raised by staff that not all of these were integrated across the different sites
- General practitioners (GPs) have access to surgical services and diagnostics with access to the surgical consultant when seeking advice. We did not speak to any GPs during this inspection but reviewed positive feedback from patients who had used the service following GP attendance.
- The bed management system was not used to its full potential with two doctors observed producing a separate patient handover system that did not feed into this patient system the two doctors we spoke with did not appear engaged with the system.
- Individualised care plans were found with the patient observations chart and care records.
- Medical records were accessible and available for doctors prior to admission.
- There were white boards on the walls of all the inpatient ward areas, which included patient details but minimum information was seen to maintain confidentiality.
- Staff within the service were informed of surgical admissions across the hospital site outside of the surgical wards. This was to support the sharing of information and to support the service users.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware and had received training for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs). The trust had a MCA and DoLS policy which was within the review date and included staff making "best interests" decision in accordance with legislation when patients lacked capacity.
- Training on consent, MCA, DoLs and learning disability was part of mandatory training for all staff. September 2016 training figures showed 70% of staff had completed this training.
- Consent to care was obtained in line with national legislation and best practice guidance.
- The trust also had a consent for examination and treatment policy which were last reviewed in 2015 and staff knew about and we saw in use across the service. We saw a range of consent forms but saw no patients with learning disabilities at the announced or unannounced visits.
- The trust's consent for examination and treatment policy supported making the patient's best interests central to the process of obtaining consent. If a young person was under 16 and wished to consent to their

own treatment, for example if they required surgery, staff followed Gillick Competency to assess whether the young person would have the maturity and intelligence to understand the risks and nature of treatments. The young person would be given time to consider all the options.
- Patients gave informal consent for their care and treatment, and this was clearly documented in their records. We observed staff asking for consent prior to undertaking care and treatment.
- Staff discussed risks and complications and gave patients the opportunity to ask questions before they asked the patient to sign their consent.

Are surgery services caring?

Good

We rated caring as good because:

- Feedback from patient's who use the service and those close to them was mostly positive about the way they had been treated. Patients told us staff were, "courteous", "respectful" and "kind".
- We observed nursing and medical staff treating patients with dignity, respect and kindness. Staff spent time talking to patients and showed compassion when patients needed help.
- Results of the CQC inpatient survey (2015) showed the trust performing 'about the same' as other trusts for all responses. In all 11 questions, they were rated about the same as other trusts. There were two areas the trust were considered worse than other trusts ,these were, patients' views – patients felt they were not asked to give their views of the quality of the care provided and information as patients felt they were not given enough information about their condition or treatment.
- Most patients told us they felt involved in their care and staff checked they understood about their care.Patients were supported emotionally and this was reflected in their care and treatment.

Compassionate care

- The Friends and Family Test (FFT) is a single question survey, which asks patients whether they would recommend the NHS service, they have received to friends and family who need similar treatment or care
- The patient responses for the FFT showed that 86% of patients would recommend this hospital to friends and family.
- Feedback from patient's who used the service and those close to them was mostly positive about the way they had been treated. Patients told us staff were, caring, courteous, respectful and kind.
- We saw good interactions and found that staff responded compassionately, treating people with kindness, dignity and respect.
- Staff were sensitive to the personal, cultural, social and religious needs of the patient and knew how to raise concerns about abusive behaviour or attitudes.
- We observed staff respecting the privacy and dignity of patients by knocking on doors and waiting to be invited in to the room, or behind the curtains around the bed space.
- Two patients informed us that they felt that staff were too busy and did not address all their concerns during the intentional ward rounding which was seen in the documentation when "settled" had been completed in the comments column.
- Intentional rounding (where nurses regularly check patient condition) was documented and we saw staff writing settled on the comments section without asking the patient if they had any concerns.This meant patients were not given the opportunity to raise any concerns they had.
- Screens or curtains were used to promote patient dignity, privacy and wellbeing, an area identified in the PLACE assessment. For May 2016 the results had reduced from 86% in 2015 to 80% in 2016 and was below the England average of 98%. However, we did not see any issues or concerns during our visit to the service.
- The day surgery area was situated away from the main part of the ward to support day surgery cases and reduce patient anxiety.
- Staff were heard respecting patient confidentiality and responding in a compassionate and timely manner, for example when a patient had been spoken to by a doctor, the nurse was heard asking the patient if she could explain the information to her and her husband again in simpler language they both could understand.

Understanding and involvement of patients and those close to them

- The trust had good results for the Care Quality Commission (CQC) inpatient survey 2015. This survey

looked at the experiences of service users in July 2015.Responses were received from 607 patients at United Lincolnshire NHS Trust. In all 11 questions, they were rated about the same as other trusts. There were two areas the trust were considered worse than other trusts, these were, patient's views – patients felt they were not asked to give their views of the quality of the care provided and information as patients felt they were not enough information about their condition or treatment.

- Three patients spoken with across the service told us, " I have no idea of my discharge date" " They have just told me I can go home in an hour" " I feel safe and have no complaints expect that the staff are completely overstretched".
- We observed visitors being provided with information about the ward and told how they could make a call to the patient's bedside.
- Staff spoken with confirmed that those close to the patient are asked to bring into the hospital appropriate clothing for the patient to use as part of the rehabilitation assessment and for the patient to wear during the discharge journey.
- Two relatives spoken with confirmed that staff could not do enough for their family members and went out of their way to ensure their needs were met.

Emotional support

- There was a multi-faith room used by the chaplaincy team who supported patients and staff. We were informed there was no formal counselling support for staff or patients.
- Staff informed us that pet therapy had been offered when an inpatient who missed the support of her pet had a visit which supported her emotionally during a long hospital stay.
- Patients told us it was noisy at night within the surgical wards and we saw that feedback on the ward boards reminded staff to reduce noise and lighting at night but there was no facility for eye mask or ear plugs used to promote sleep.
- Theatre areas were secure and children and adults areas were separate for recovery areas.
- Screens or curtains were used to promote patient dignity, privacy and wellbeing, an area identified in the PLACE assessment. For May 2016 the results had reduced (from 86% in 2015) to 80% and was below the England average of 98%. However, we did not see any issues or concerns during our visit to the service.
- The day surgery area was situated away from the main part of the ward to support day surgery cases and reduce patient anxiety.

Are surgery services responsive?

Good

We rated this service for responsive as good because:

- Performance remains at the national average for patient plans of care following admission and pathways
- The trust was in line with the England average for referral to treatment times (RTT) between July 2015 and June 2016.
- The trust had implemented a number of actions as part of its improvement plans to address issues in relation to cancelled operations, waiting times and theatre utilisation.
- Bed occupancy rates were 82.3% lower than the England average of 85.9%.
- The average length of stay for for elective surgical patients was 2.9 days between March 2015 and February 2016 lower than the England average at 3.3 days. Non elective surgical patients stay was 4.8 days compared to the England average of 5.1 days.
- The trust had introduced a carer's badge for family members or identified main carers to support them and identity those who provide care to those who require continuity with carers.
- From September 2015 to April 2016 the trust reported no mix sex breaches.

However:

- Between July 2016 and Sept 2016 there were 33 failed discharges across this service. This meant patients were readmitted back into the service within 72 hours which resulted in cancellations for planned surgical admissions due to no available beds.
- Systems were not robust to identify vulnerable patient groups that included patients living with dementia and patients with learning disabilities.

Surgery

Service planning and delivery to meet the needs of local people

- The service admitted elective and emergency general surgery,emergency and elective orthopaedic patients in addition to other specialities and vascular surgery.
- Service reconfigurations meant that not all procedures were completed at Pilgrim hospital or across the trust. In an emergency situation patients would be stabilised before they were transferred to the specialist centre.
- Local clinical commissioning groups and the national commissioning board commissioned services within the trust and regular meetings were attended by a trust representative.
- Surgical ward developments included a dining area on the vascular ward to promote patient rehabilitation and increase confidence following amputation by encouraging interaction at the dinner table with other patients.
- Theatre areas were secure and children and adults areas were separate for recovery areas.
- There was no dedicated psychiatric or counselling support for patients undergoing a limb amputation as a result of poor blood supply.
- We saw mixed sex wards with staff meeting same sex accommodation guidance by maintaining single sex dedicated bays. This was in line with national guidance.
- Senior staff said same sex accommodation was not a problem and any breaches were reported. There were no breaches submitted from this service for between January and September 2016.
- There were information leaflets and ward boards for visitors within the ward entrance area.
- Visiting times were clearly marked at each ward entrance on the "Caring for You" boards (12:30pm until 8pm) but staff recognised that family members who had travelled into the area required some flexibility.
- There was a room available within the hospital where long distance visitors could stay overnight
- There is currently no amputee liaison clinical nurse specialist and the nearest limb support centre is based at Nottingham which involves considerable travel for this client group
- Counselling services were not available within the vascular service where staff reported the initial response of patients following emergency surgery for amputation when counselling support was required.
- Sister described the recently launched local amputee support group who meet in the dining area.

Access and Flow

- Operational meetings were held three times a day to discuss patient flow and identify any additional support required for patient discharge. Staff attended from surgery to review all admissions and discharges while considering any possible outlier transfers into or from this service.
- We saw no cross hospital site bed system for surgery to support staff in knowing bed capacity or patient flow.
- The trust's referral to treatment time (RTT) for admitted pathways for surgical services had been lower than the England overall performance since July 2015. The latest figures for June 2016 showed 67.9% of this group of patients were treated within 18 weeks. The trust's performance over this time has been quite static and followed national trends.
- The following specialties at this trust were above the England average for admitted RTT (percentage within 18 weeks); Cardiothoracic Surgery at 92% performed across sites.
- The following specialties at this trust were below the England average for admitted RTT (percentage within 18 weeks); general surgery, ophthalmology, urology, trauma & orthopaedics, ear nose and throat (ENT) at 84%.
- Bed occupancy for the trust in March 2016 was 82.3% below the England average of 85.9%.
- Staff told us that patients were sometimes held in adult recovery longer than clinically required due to the lack of speciality a beds. Staff recognised the issues they faced and worked with other ward colleagues to reduce further occurrences of patient delays in recovery.
- Staff told us that it was uncommon to have surgical patients on other wards but it was more common for medical patients to be nursed as outliers on surgical wards. We saw the medical registrar attending the ward to review his patient on the second day of inspection before starting his medical ward round which meant that the staff were aware of the patient care plan at the beginning of the day and this prevented a cancelled surgical admission.
- If day surgery patients were assessed as not being fit for discharge they were transferred to the ward until they were assessed as medically fit.

- Between July 2016 and Sept 2016 there were 33 readmissions across this service. This meant patients were readmitted back into the service within 72 hours which resulted in cancellations for planned surgical admissions due to no available beds.
- Between October 2015 and September 2016 we saw there were 61 discharges or transfers from this service between 2200 and 0600hrs which was not conducive to a good patient experience for those patients involved.
- Between January and March 2016 there were 120 cancelled operations for non-clinical reasons.
- The number of patients who had surgery cancelled and not rescheduled within 28 days totalled 83 for 2015. While between January and March 2016 there were 16 patients confirmed.
- There were a number of cancelled operations at Pilgrim hospital. The trusts performance in relation to cancelled urgent operations as a percentage of patients whose operation was cancelled and not treated within 28 days was higher than the England average during the period October to December 2015 and April to June 2016. It was lower than the England average during July to September 2015. We were informed that there were approximately 30 cancelled operations a month due to delays or other non-clinical reasons but that staff tried "everything possible" to prevent cancellations.

Meeting people's individual needs

- A named nurse was identified each shift to ensure the patient knows who was caring for them and to provide continuity of care through the day.
- Many leaflets throughout the unit were available in other languages for example, vascular services information was available in other languages on request or larger font or braille.
- Staff were familiar with and knew how to access translation services. Staff told us they could access the service at any time to support patients that required assistance with their communication needs.
- We saw limited signage in different languages to enable non-English speaking patients and visitors to be directed to the appropriate part of the hospital site.
- Patients were offered food and drink when it was clinically safe to do so and those patients we spoke with told us they had no concerns with the hospital food.
- There were lead nurses for dementia and learning disabilities who helped in the assessment of individual patients and provided guidance to support patient needs. The dementia leads visited patients over 75 years of age in line with national dementia screening. They visited patients across the hospital to support, offer activities and provide enhanced care. There was a dementia care pathway for guidance on interventions to support patients.
- Patient information within the ward areas was clear and up to date. Materials on notice boards were relevant and in date, for example we saw guidance for patient's discharge, advice and support.
- Single sex bays were seen across the wards and Bostonian Ward was all single rooms.
- We observed a patient with complex learning disability needs was well supported with detailed documentation of referral to the learning disability lead who reviewed their care.
- There were no teenage admissions on the ward at the time of inspection. We discussed and staff confirmed they were well supported within the wards and admitted if appropriate to single rooms.
- There was no identified physiotherapist for surgery that meant patients could be seen by a different individual throughout their care. This could be a problem for some group of patients, for example patients with learning disabilities.
- We saw a patient concern was raised on one of the ward boards about noise at night and disturbed sleep. There were identified actions completed such as staff being mindful of reducing the noise levels at night but no mention of eye masks or earplugs (which we were told were withdrawn following a reported incident in another hospital).
- Discharge planning started at the preoperative assessment stage for elective patients and on admission to the ward for trauma and emergency patients.
- There was access to a mental health liaison team, which was available for patients within the hospital 24 hours a day.
- There was clear signage for meals and menus available in alternative languages or larger font
- One ward has a dedicated dining room which was part of patient rehabilitation and confidence building prior to discharge home.
- We saw placemats that other wards already used being introduced by the ward sister in their area. The placemat has typed information across its surface which included "Caring for You" information. This included for

example, the ward sister and matron photographs and names, visiting hours, calling for help, pain, who's who uniform explanation, and what to do if you have worries and concerns. This meant that immobile patients would have information other mobile patients saw on the ward board.

- There was no amputee liaison clinical nurse specialist and the nearest limb support centre was based in Nottingham which involved considerable travel for this client group.
- Counselling services were not available within the vascular service where staff reported the initial response of patients following emergency surgery for amputation when counselling support was required.
- Sister described the recently launched local amputee support group who meet in the dining area.
- There was restricted routine visiting times for family and friends and one sister told us she allowed visitors to assist with feeding at mealtimes so they could attend outside of the restricted times. We saw other staff allowing visitors access outside of visiting hours to meet the patient needs.

Learning from complaints and concerns

- Staff told us - that all complaints were handled in line with the trust complaints policy and support from the patient advice and liaison service (PALS) team. Information on how to make a complaint was seen on the ward board. The complaints policy was last reviewed in August 2015.
- Staff were aware of the trust's procedure for dealing with complaints and concerns and knew how to access the complaints policy through the trust intranet. Staff told us that they dealt with complaints in an open and honest way and dealt with complaints before they escalated.
- Senior staff informed us that staff had shared learning of complaints across the Trust sites which was evidenced by the introduction of eye masks to support night rest.
- There were 123 complaints received between June 2015 and May 2016. The top five themes identified were for clinical treatment (77), communication (23), waiting times (9), patient care(7) and appointments (7).
- Concerns were raised by three patients who told us of their concerns when a nurse of the opposite gender provided them with personal care and also when care was not provided but was required by a diabetic patient. The patients did not feel confident enough to raise their concerns with senior staff and due to poor mobility, where unable to see the "caring for you" notice board which informed patients of how to raise worries and concerns through PALS. When this was discussed with senior staff she confirmed this issue would be resolved with the introduction of the ward information placemat but she agreed to review all patients before the next intentional round and address individual concerns raised.
- Managers told us that complaints were discussed in team briefings and meetings so lessons learnt could be shared and staff made aware of complaints that were being dealt with. Staff spoken with across the service were aware of the complaints within this service. The number of complaints were displayed on the ward boards for information sharing.
- Staff confirmed team meetings included discussions about complaints as a positive part of the feedback of the service. Managers said they informed staff of events and incidents within their areas of work.
- We spoke with a patient who said " I would say that the staff explained everything to us and what to do if I want to make a complaint and given the information needed.
- PALS information leaflets were seen displayed in clinical areas and information about contacting PALS was available on the trust's website.
- Senior staff addressed patient complaints and visited patients to discuss their complaints. After complaining patients were offered the opportunity to receive a letter or meet face to face to discuss the complaint. After the meeting, or a notes review, a record of the actions were sent to the patient or family.
- We saw minutes of meetings highlighting to staff that poor communication was one of the top causes for complaint. Staff were encouraged to ensure patients understood when discussing care as a result of complaints.
- All complaints across the trust were presented centrally into a patient experience report, which was presented to trust board.
- Following recent patient feedback noise at night had been identified as a concern. As a result agreed actions included the reduction of telephone volumes and the turning off lights.This had been cascaded to staff through the staff handover meetings.

Are surgery services well-led?

Surgery

Good

Overall we rated well led as good because;

- There was a governance structure in place to support safe and effective care.
- Routine audits and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Audit or patient feedback outcomes were discussed and actions or learning points communicated to all other staff in the department through governance or performance meetings, during handover or through one to one meetings.
- We heard that staff generally felt supported by visible local leadership.
- All staff were passionate about their role and wanted to provide good patient care.
- The nursing teams at ward level provided support to each other with senior staff working clinically for two days a month.
- Morale in theatres was good with staff retention supported by strong leadership.
- The surgical division held its own risk register and clinical leads identified the top risks.

However;

- Risks were not always dealt with appropriately or in a timely way. For example the emergency call bells were on the risk register since 2014 but minutes at the governance performance meeting in May 2016 showed that the risk remained unresolved.

Vision and strategy for this service

- United Lincolnshire Hospitals had a clinical services strategy for 2016 to 2021 but not all staff spoken with were involved in the development of the strategy.
- Senior staff spoke of the local vision and values for the service for the next five years with the trust working as an integrated service and ensuring that patients received improved and safer care.
- There was minimal awareness of the vision and strategy amongst staff, although each surgical ward displayed the trust values. Staff spoken with were not involved in creating the values but stated they would be happy for their families to be nursed within the service.
- Senior staff confirmed progress against delivering the strategy is monitored and reviewed at the divisional and team meetings which were evidenced in minutes reviewed.

Governance, risk management and quality measurement

- The governance and risk structure in place had guidance to support safe and effective care, and ensure that risk management was consistent with trust risk management policies,for example the management of hospital acquired infections.
- We were told the governance arrangements and structure had been strengthened over the past year with monthly governance meetings and quarterly trust wide meetings. Risk management staff had been appointed to work proactively with wards with audit leads, matrons and the policy group to recognise and raise concerns.
- The surgical division held its own risk register and clinical leads identified the top risks. Nursing and medical staff were aware of risks locally, the majority of staff stated that recruitment and locum agency staff caused the highest risks within the organisation. The leads for the service also identified staffing as being in the top three risks for the service.
- Risks were not always dealt with appropriately or in a timely way. For example the emergency call bells were on the risk register since 2014 but minutes at the governance performance meeting in May 2016 showed that the risk remained unresolved.
- The structure within the division meant that there were speciality governance meetings held within the service. Monthly meeting minutes reviewed included safety and quality group meeting, governance and performance meetings for general surgery, breast surgery, urology, anaesthesia, head and neck and trauma and orthopaedics. These meetings discussed risk, governance and quality such as incidents. Staff confirmed they were able to raise concerns about patient safety and clinical audit outcomes. Actions were identified at each meeting with an update seen with progress at the following meeting. Information for safety and incidents, environment, patient experience, staff experience and nurse staffing was collected monthly to provide an overview of the service's performance.
- Routine audits and monitoring of key processes took place across the ward and theatre areas to monitor

performance against objectives. Audit or patient feedback outcomes were discussed and actions or learning points communicated to all other staff in the department through governance or performance meetings, during handover or through one to one meetings. Information relating to performance against key quality, safety and performance objectives was monitored and shared with staff through performance dashboards that were displayed on noticeboards.

- Quality and performance data was monitored through trust wide governance meetings that fed into the business unit performance review. The quality and safety dashboard was displayed within most ward areas.
- Effectiveness of this service was monitored at the governance and performance and quality and safety meetings. Quality and performance indicators were discussed, for example, RTT times, medical outliers, actual and planned admissions, and service risks.
- Staff told us that work constraints restricted the opportunities to attend governance meetings and development opportunities
- The minutes for both the theatres,anaesthesia and surgery business and clinical governance monthly meetings demonstrated that key governance areas were reviewed and monitored including incidents, complaints, estates and policies. Examples included surgical site infection rates, average length of patient stay, readmission rates and complaint themes.
- Senior staff demonstrated that they followed the National Safety Standards for Invasive Procedures (NatSSIPs) (September 2015) standards which include a set of recommendations that help provide safer care for patients undergoing invasive procedures. The principle of NatSSIP is that organisations review their current local processes and work in collaboration with staff to develop their own set of Local Safety Standards for Invasive Procedures (LocSSIPs).
- Senior staff spoken with told us that there was now a focus on forward planning. However, we saw that bed capacity was a challenge with non-surgical patients admitted to surgical wards.

Leadership of service

- A head of nursing, clinical director and divisional operation manager provided leadership for the surgical services. Staff confirmed there had been recent changes with the interim head of nursing now employed into the permanent role.
- Monthly ward meetings were held with matrons, ward sisters and their staff.
- Staff told us that there had been lots of improvements within the last eighteen months,for example substantive management appointments.
- We heard that staff generally felt supported by visible local leadership. Staff were able to name the chief executive officer (CEO) and director of nursing (DON).
- Matron visited the wards and theatres daily.The matron completed two clinical shifts a month within the service. Matrons were noteably visible each day on the wards.
- On the unannounced inspection some staff spoken with stated that senior staff were not always on the ward as they had been during the inspection.

Culture within the service

- All staff were passionate about their role and wanted to provide good patient care.
- The nursing teams at ward level provided support to each other with senior staff working clinically for two days a month.
- Morale in theatres was good with staff retention supported by strong leadership.
- Ward staff informed us that they were supported by their managers but morale was variable between areas.
- Staff informed us they did not always declare all staff numbers to avoid staff being moved to cover shortages in other wards. We asked why this happened and were informed that some ward staff felt they were always moved as their area coped well and had fewer vacancies than other areas.
- Some staff informed us that concerns were escalated but nothing happened, for example the absence of emergency call bells.
- There was a strong culture of support between nursing and medical staff.
- Staff raised concerns regarding the current staffing vacancies.

Public engagement

- Patient and carer feedback was included in ward staff handovers.
- The patient experience team collected correspondence received from feedback in the form of cards or letters. The team provided information of the total of responses to each ward. The ward displayed figures under the heading ‘counting complements’.

Surgery

- There were patient information leaflets seen across the surgery wards and in every area feedback cards were available for patients.
- The trust website and social media were used proactively across the service for patient feedback.
- The hospital was involved with the local area and we saw fund raising events and notices for future events to support the service.
- We were informed of several surgery patient experience groups which met and provided staff with feedback of their patient experience.
- We saw "ward health safety quality dashboard" in all clinical areas. These were reviewed monthly. Results were available in public areas of the ward.
- We were told the service engaged with internal and external stakeholders which included patients, partners and staff to plan services. The trust engaged service users and members of the community to join local forums to help shape the future of the services provided.
- We saw comment cards for patient feedback and staff were proactive with supporting patients to complete them. The vascular sister told us of improvements agreed within the ward environment to provide a patient rehabilitation assessment kitchen based on that feedback.
- Caring for you boards were seen up dated at each ward entrance which gave patients and their relatives the quality information they required.

Staff engagement

- There were monthly staff ward meetings minutes displayed on the wards to cascade information to staff supplemented by a ward newsletter and a staff information board.
- Daily ward board meetings were also used to discuss important information.
- Senior surgical ward staff spoke of shared learning across the hospital sites.
- Staff informed us that they were supported when they attended study days or training internally and externally to the trust.
- Listening in Action was maintained and staff confirmed their involvement. Listening into Action is a national improvement programme led by executives and involved staff to identify areas of concern and support them with resolution.
- Three out of six staff we spoke with were aware and were engaged with the trust improvement plan. They were aware of the the issues that were being faced and worked to achieve performance targets.
- Safety and quality concerns were discussed at all team meetings.
- We saw and staff were aware of the recent addition of the 'United Lincolnshire Hospital Trust Together' social media page. This page included general information, praise, and comments to staff and departments.
- The chief executive wrote a monthly blog and newsletter to staff, which staff spoke about.
- Staff told us they contributed to the staff survey and listening into action (LiA).

Innovation, improvement and sustainability

- The organisation recognised long service and awarded staff for their commitment to the organisation.
- Staff awards were held annually to recognise staff contribution and achievement. Categories included staff work with going the 'extra mile', 'team of the year', 'compassion and respect' and 'great patient experience'.
- A team of the year award for 3b was presented in 2015 from the organisation team awards and individuals from this service had been nominated for local recognisition awards in 2016. The surgical team on ward 3b had received a nomination letter for the team of the year awards for 2017.
- We saw a business plan "Key to Care" where educational opportunities to support professional development and revalidation for agency staff was outlined. For every 75 hours of work in a one month period, the trust provided seven and a half hours of continued personal development (CPD) credit for the individual to access free training in the trust.
- Business plans were written and funding approved for a paperless electronic system.

Critical care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

United Lincoln Hospital NHS Trust (ULHT) has 32 critical care beds, of which 97% are adult and three percent are neonatal. For the purpose of this inspection, we reviewed the adult critical care provision at Pilgrim Hospital Boston, where there are nine funded critical care beds.

The nine adult critical care beds have the facilities and staff to care for patients requiring intensive care (level three) or high dependency care (level two) as defined by the Intensive Care Society 2009. Level two patients are those requiring more detailed observation and intervention including support for a single failing organ system, or post-operative care and those 'stepping down' from higher levels of care. Level three patients are those requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multi-organ failure.

The critical care unit was responsive to local demand by using beds flexibly according to the level of care required. The unit worked collaboratively with the colorectal cancer service to provide facilities and care for the post-operative patients at level one (enhanced ward level care).

There were 591 admissions to Pilgrim Hospital critical care unit between April 2015 and March 2016.

A Critical Care Outreach team provides a supportive role for medical and nursing staff when dealing with deteriorating patients throughout the hospital and supports those patients discharged from critical care. This service runs alongside critical care although under the management of acute care services.

During our inspection, we spoke with 23 members of staff including managers, consultants, doctors, nurses, physiotherapist, assistant physiotherapist, junior doctors, health care assistants, data clerk and professional development nurse. We also spoke with four patients and their visitors.

Critical care

Summary of findings

Overall, critical care service was rated good for safe, effective, caring, responsive and well led.

- The critical care unit appeared visibly clean and promoted patient safety through established infection control processes, with no reported incidents of meticillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (C.Difficile). Local audits showed staff consistently used good hand hygiene practices and were bare below the elbow in line with best practice.
- There was adequate medical and nursing staff to meet the recommended staff to patient ratio, as defined in the core standards for intensive care units.
- The department planned and provided care according to national and local guidelines and was an active member of the Mid Trent critical care network, where common working policies were developed and agreed.
- We observed staff providing compassionate care and maintaining patient privacy and dignity at all times.
- The unit was responsive to local demand by using beds flexibly according to the level of care required. The unit worked collaboratively with the colorectal cancer service to provide facilities and care for the post-operative patients at level one (enhanced ward level care).
- Patients were supported on discharge by the critical care outreach team .Those receiving level three (Intensive care) had the opportunity to attend a post critical care clinic for longer-term support.
- The service was led by experienced senior manager with the skills and capability to lead the service effectively .Staff told us they felt supported to carry out their roles within the unit.

However

- The critical care unit informed the inspection team that delayed patient discharges was a problem for the unit and this was on the departments risk register. However, the unit did not keep a comprehensive record of delayed discharges.
- The critical care unit did not have the recommend number of nurses with a post registration qualification in critical care nursing as defined in the core standards for intensive care units.

Critical care

Are critical care services safe?

Good

We rated critical care as good for safe because:

- There was a positive incident reporting culture with learning and sharing evident within the unit.
- There was no reported hospital acquired infections within the critical care.
- Equipment was maintained and readily available as required.
- Medical and nurse staffing numbers met recommended levels with specialist consultant availability 24 hours a day.
- Medicines were stored correctly and securely with swipe card access for qualified, competent staff only.
- All staff had safeguarding training and were confident in escalation processes.

However we also found:-

- Safety thermometer outcomes were not displayed meaning staff and visitors were not informed of safety outcomes for the unit.
- There was not an established program for the capital replacement of equipment in line with Standard for Equipment in Critical Care.

Incidents

- Information provided for the period August 2015 to July 2016 showed there were no never events reported within critical care. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- Staff were able to describe how to report incidents and gave examples of where they had completed an electronic incident report. Staff received acknowledgement through automatic personal emails and feedback was provided at staff meetings. We saw evidence of this within meeting minutes.
- Data provided by the trust showed no reported serious incidents, 23 moderate incidents and 452 no or low harm incidents for the period August 2015 to July 2016. Incidents are categorised according the impact. Serious are those which appears to have resulted in permanent harm, moderate are those resulting in increased treatment and caused significant but not permanent harm, low are incidents requiring extra observation or minor treatment and no harm are those with the potential to cause harm but were prevented (near misses).
- The high number of no harm incidents was attributed to delayed discharges from critical care to the ward at Pilgrim Hospital.
- Senior nurses could describe the incident investigation process according to trust policy for incident management. This included statement gathering, root cause analysis and action planning. Examples of learning following incidents included improved pressure ulcer prevention through the purchase of pressure relieving chair cushions and the implementation of an improved handover document for patients being transferred to a ward.
- Staff were familiar with the term duty of candour and the importance of being open and honest when errors occur. Duty of candour means as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Mortality and Morbidity meetings took place monthly with attendance by the multidisciplinary team involved in the treatment of the patients being discussed. We reviewed the minutes of these meetings, which included detailed case presentations and recommended actions.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter and risk of blood clots or venous thromboembolism.
- Safety thermometer outcomes were not displayed; this meant staff and visitors were not openly informed of safety outcomes. However, a printable version was available through the trust intranet to which staff had access. We reviewed the safety thermometer outcomes, on the intranet, which showed for the period January to June 2016 there had been zero harm recorded for the four avoidable harm categories.

- Patients within critical care were assessed for venous thromboembolism risk on admission and throughout their stay on the unit. This was recorded within the electronic patient records.

Cleanliness, infection control and hygiene

- The critical care unit appeared visibly clean and tidy with access to sinks for hand washing.
- Hand cleansing gel was provided at the entrance to the unit and throughout the unit. We observed staff washing their hands or using hand-cleansing gel before and after any contact with patients.
- Hand washing audits for the period January and June 2016 showed compliance to be 98%.
- Staff were bare below the elbow, in line with good infection control practice.
- Personal protective equipment (PPE) including gloves and aprons were available throughout the department.
- There were two single rooms within the unit, which had a gowning lobby to facilitate barrier nursing. However, although these rooms were within critical care, they were infrequently used due to accessibility and visibility.
- Data provided by the trust indicated critical care had had no incidences of methicillin-resistant Staphylococcus aureus (MRSA) or clostridium difficile (C.Difficile) for the period January 2015 to June 2016
- The department informed us of a recent occurrence of patient infection with Stenotrophomonas maltophilia (a bacterial infection). The source of the infection was identified to have been water used, for washing patients, from the sink taps within the unit. An immediate action had been the temporary placement of filters on the sink taps and a plan was in place to replace the current sensor tap system with a lever mechanism by the end of November. This would enable the taps to be run for a longer periods, therefore flushing the system. Staff had been reminded to dispose of patient washing water in the sluice area. Following these actions no further contamination had been identified
- Intensive care national audit and research centre (ICNARC) data indicated unit acquired blood stream infections to be comparable to other units at 1.8 per 1000 patient days. The average across all other units collecting ICNARC data was 1.5 per 1000 patient days.
- United Lincoln Hospitals NHS Trust (ULHT) had a sepsis action plan 2016/17. This was developed in response to a trust wide sepsis review carried out in in 2015. This included the launch of a sepsis bundle in April 2016, providing clear guidance on the detection and treatment of suspected sepsis.
- Clinical waste was segregated and disposed of appropriately in the sluice area.

Environment and equipment

- The critical care unit had been refurbished in 2012 to comply with health building note (HBN) 04-02.
- All bed areas were spacious and equipped to facilitate the monitoring and treatment of patients requiring up to level three care. Level three care means patients requiring advanced respiratory support, alone or in conjunction with other treatments.
- Each bed area had overhead facilities for the safe lifting of patients.
- Equipment used within critical care was maintained through existing manufacturer guarantee or by hospital technicians. Green stickers were placed on equipment identifying recent and planned service dates. All equipment we saw was within its indicated maintenance date.
- The department had a spreadsheet recording all items of equipment, manufacturer, serial number and purchase date. The hospital clinical engineering department had key performance indicators (KPI's) for equipment to be inspected and maintained with a target of 80%. Records indicated this target was being achieved.
- Staff told us equipment was always available when needed and the equipment store appeared to have ample supplies of regular use items.
- The unit was undertaking a trial of new ventilators (machines used to provide artificial respiration for level three patients) to replace equipment their existing ventilators which were becoming outdated. Staff told us they were involved in the evaluation process for all new equipment.
- There was an equipment competency pack, overseen by the professional development nurse (PDN). Record of observed and self-assessed competencies for all equipment used was maintained.
- Resuscitation equipment was visible and easily accessible to all areas of the unit. Records showed the resuscitation trolley was checked daily and signed as complete. All disposable items were in date.

- Bedside equipment was checked during the handover of each shift.
- Staff were able to control the environmental temperature to enable patient and staff comfort.

Medicines

- Medicines were stored correctly and securely. Medicine cabinets were stocked in alphabetical order to aid swift identification.
- Access to the medicines storeroom was by swipe card. All registered nurses had swipe card access to the medicines storeroom.
- We saw medications being checked by two nurses prior to administration, which reflects good practice.
- Control drug registers were completed, including a record of stock level, which reflected the actual stock level within the store cupboard. Controlled drugs come under the Misuse of Drugs legislation and require specific storage and administration records. Examples include morphine and pethidine.
- A named pharmacist visited the critical care unit daily to review the electronic prescriptions. However, the pharmacist did not attend the multidisciplinary ward rounds as recommended within the core standards for intensive care units.
- Fridge temperatures were recorded daily to ensure the safe storage of temperature sensitive medications.
- The unit had electronic prescribing to which registered clinicians could access. The system had a number of failsafe systems such as review dates and calculations according to patient weight. This promoted safe prescribing and timely reviews of drug treatments. Patient allergies were also recorded on the electronic system.
- The critical care unit had daytime telephone access to a microbiologist for advice related to antibiotic prescribing and on-call access for out of office hours. The trust had an antimicrobial prescribing policy.
- There were no reported delays in access to specific medicines.

Records

- The critical care unit had an established electronic records system which staff told us was user friendly.
- The full range of patient risk assessment was included with a flagging system for any omissions or review dates.
- Free text boxes enabled medical, nursing or allied professional staff to record interventions and decisions relating to patients daily care. Additionally there was a section for recording communication with family or carers.
- We reviewed the electronic records of four patients with the assistance of the staff caring for those patients. We found all required assessments had been completed and the staff demonstrated how the system indicated when further assessment or input was required. Free text included clear descriptions of care and treatment provided.
- At the point of transfer to the ward, key documentation was printed off. However, observation charts remained electronic due to the potential size of the documentation. These could be viewed by ward staff if required.
- Existing medical notes were stored, out of site in workstations next to each bed space. This meant patient confidentiality was maintained.

Safeguarding

- All staff within critical care had received safeguarding training to level two, which meets the requirement for staff caring for adult patients. This exceeded the trust target of 95%. The critical care unit at Pilgrim hospital did not admit children.
- There were information within the unit relating to safeguarding adults and information boards in the visitors waiting area with information and contact numbers on a range of subjects including domestic abuse.
- Staff spoken with were confident in their knowledge of safeguarding and were able to give examples of when they would raise a safeguarding concern.
- The trust had a policy for reporting female genital mutilation (FGM) which was available on the intranet. FGM means partial or total removal of the external female genitalia for non-medical reasons.

Mandatory training

- Staff throughout the critical care unit told us they were up to date with all mandatory training or had dates to attend required training sessions. Data provided by the trust showed overall core learning compliance to be 95% for nursing staff and 68% for medical staff. Subjects included were fire safety, infection control, equality and

diversity, information governance, safeguarding, health and safety, slips trips and falls, manual handling, risk and fraud awareness. Trust target for compliance was 95%.

- Basic life support (BLS) was added to core learning in April 2016. Compliance up to September 2016 was 41% for nursing staff and 67% for medical staff. Dates for BLS training had been agreed with a trajectory for trust compliance by March 2107.
- In response to a trust sepsis review in 2015, an e-learning package had been developed for all front line staff. Staff spoken with on the critical care unit told us, sepsis training was part of their local, trust induction, and was included in mandatory training. All staff with the exception of those on maternity or other long-term leave had completed this training.
- Mandatory training was routinely reviewed at annual appraisals and attendance was a supported priority of the unit

Assessing and responding to patient risk

- Risk assessments were completed and recorded for patients in the critical care unit using the electronic records system. This included mental capacity assessment, and observations for the development of delirium. Delirium is an acute, reversible, mental disorder, which can occur as a result of disordered sleep-wake cycles, resulting in a range of symptoms from withdrawal to agitation.
- Observations were recorded on the electronic system which automatically added up a national early warning score (NEWS). NEWS was a nationally recognised patient assessment tool that scores a patient in relation to regular clinical observations such as temperature, pulse, blood pressure and respiratory rate. The score was an aid to recognising a deteriorating patient and gives clear instruction for escalation, from increased frequency of clinical observations, to urgent medical intervention.
- We observed staff using the electronic system and saw how it could highlight the need for intervention or highlight omissions.
- A critical care outreach team (CCOT) was available to the critical care unit 24 hours per day. CCOT reviewed all patients transferred out of critical care and provided on-going support to staff caring for these patients on the wards.

Nursing staffing

- At the time of our inspection, there were no nursing vacancies and a senior nurse told us there were nurses waiting for positions to become vacant on the unit.
- Critical care had nine beds, five at level three (Intensive care) four at level two (high dependency). The staffing numbers met the requirement of the Core Standards for Intensive Care Units (2013) of one nurse to each level three patient and one nurse to two level two patients.
- There were 47 whole time equivalent (WTE) registered nurses including one WTE band seven-nurse educator, two WTE band seven nursing sisters with one day per week management duties, seven WTE band six nurses and 36.5 WTE band five nurses. In addition, there were five WTE health care assistants, two WTE technicians, one data clerk and three receptionists.
- The skill mix enabled flexible working between level three and level two care; meaning when there was a greater ratio of level three patients the unit was able to provide the required one to one care.
- There had been no agency use in the preceding two years. However, bank staff had been utilised to cover absences when needed. All bank provision was by existing critical care staff working additional hours.
- The trust had an induction checklist for bank and agency staff if needed.
- The majority of nurses worked a 12-hour shift with handovers at the beginning of each day and night shift. Additional handovers took place at mid-day for staff working the more traditional early / late shift system. During the inspection, we observed a morning handover and patient allocation, which gave a general overview of patients on the unit. This was followed by a detailed handover at the patient's bedside.
- Nurse rostering was through an electronic system and staff told us they were able to request shifts or swap shifts to meet their personal needs and requests for annual leave was fairly approved.

Medical staffing

- At the time of our inspection, there were eight critical care consultants. Seven permanent and one locum. In addition, there was one retired consultant providing clinical supervision.
- The consultant intensivists worked a one in eight rota. This meant critical care had intensitivist cover 24 hours per day. The provision also met the core standard requirement of access to a consultant intensivist within 30 minutes at all times.

Critical care

- Consultant ward rounds took place twice daily.
- The consultant to patient ratio met the best practice recommendations of the Core Standards for Intensive Care Units (2013) of one consultant to 14 patients. This meant the unit was able to meet the needs of patients and support consultant wellbeing.
- All consultants were appropriately qualified and fellows of the royal college of anaesthetists.
- Middle grade cover was through a resident on call arrangement covering 24 hours. In addition to this foundation, doctors FY1 (junior) are rostered 8am to 5pm each day.
- A multidisciplinary team (MDT) handover took place each morning. We observed the morning handover and found it gave a comprehensive overview of patients on the unit and their treatment plan.

Major incident awareness and training

- The trust had a surge plan which covered actions in the event of a major incident. Staff told us they were aware of the document, which was available through the critical care electronic system.
- There was a critical care surge/capacity escalation plan for Pilgrim hospital, which covered a range of situations and included required actions following activation of the surge plan through to completion and stand down.
- Staff were not aware of their individual responsibilities, in the case of a major incident. However, they told us they would respond to instructions from the lead nurse on duty. The lead nurses we spoke with were familiar with the actions to take in the event of a major incident, including establishing communication with the major incident control centre.
- There had been no simulation events in the critical care unit.

Are critical care services effective?

Good

We rated critical care as good for effective because:

- Patients care and treatment was planned and delivered in line with national and local evidence based guidance, standards and best practice.
- There was ready access to information, which enabled staff to plan and deliver care effectively.
- Staff were supported to develop their critical care competencies through an established in house training programme.
- Patients reported good levels of pain control.

However:

- The unit did not meet the minimum requirement of 50% registered nursing staff in possession of a post registration award in critical care nursing.
- We found limited access to dietetic services to support the nutritional needs of patients within critical care.
- Limited support from pharmacy, dietetics and microbiology meant these services were not integral to the critical care multidisciplinary team.

Evidence-based care and treatment

- The critical care unit used national and local guidelines to plan and deliver effective care. These included National Institute for Health and Care Excellence (NICE) and Mid Trent Critical Care Network (MTCCN).
- Staff had access to guidelines, policies and protocols through bedside computers and demonstrated how they used these documents when planning care. Examples included a critical care bundle for weaning patients from artificial ventilation (mechanical respiratory support). This is a series of actions which enables staff to evaluate a patients readiness and progress towards breathing for themselves independently through to planning for rehabilitation after a critical illness which includes access to follow up clinics and where applicable allied professional support, (physiotherapy & dietician).
- The unit was an active member of MTCCN and adhered to the agreed policies produced by the network. These included admission and discharge criteria and agreed protocols for transferring patients within the network. The MTCCN was a group of geographically close critical care units which worked together to provide consistency of treatment and care through shared audits and common policies.
- The lead consultant oversaw audits carried out within critical care. Examples included sedation on critical care, critical care referral documentation and awareness of anaesthetic guidelines for care of the bariatric (heavier) patient. We saw documentation relating to the

critical care program of audit, which included outcomes, actions and author summaries. Audits provided evidence of compliance with national and local guidelines.
- Audits and outcomes were discussed at intensive care clinical meetings; we saw evidence of this in the July and September 2016 Pilgrim critical care clinical meeting minutes.
- The critical care unit subscribes to the Intensive care national audit and research centre (ICNARC) which produces quarterly and annual reports with data, which is benchmarked against similar sized units within England and with critical care generally
- 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.
- The unit had a pathway for the management of delirirum in frial adults.

Pain relief

- Pain control was monitored and reported on the electronic patient record and was reviewed by consultants on the ward rounds. For conscious patients pain was rated as one to three according to severity.
- We spoke with three patients who told us their pain had been controlled and staff frequently asked them if they were uncomfortable or experiencing any pain. We saw a range of pain control was available such as epidural (anaesthetic medicine injected into the spinal epidural space, causing numbness), intravenous (directly into a vein) and oral (by mouth).
- The hospital had a pain management service available for advice and support and was contactable by telephone. However, staff told us pain was generally managed on critical care by the intensivists.

Nutrition and hydration

- Staff completed a malnutrition universal screening tool (MUST) screening for patients admitted to critical care. 'MUST' was a five-step screening tool to identify adults, who are malnourished or at risk of malnutrition.
- We saw where patients were able to eat and drink they were supported to do so and offered a choice of meal options. Fresh water was provided and visitors are encouraged to assist patients where appropriate.
- Critical care have 30 hours a week of funded dietetic support; this was not always received in full due to capacity within dietetics but should there be a need for urgent input, the dietetic service can be contacted directly. There was no routine assessment by a dietician for patients admitted to critical care. Pharmacy support the unit with provision of parenteral feeding and there is the provision to store a small amount of TPN in the unit for the weekends if required. Supplements were also offered and sourced from pharmacy on the advice of the dietician.
- The unit followed the MTCCN guidelines for nutritional support of patients in critical care. This included a flow chart to aid selection of the most appropriate feeding regime. Feeding for medical patients was commenced within 24 to 48 hours following discussion on the morning ward round. Surgical patients were commenced on a feeding regimen prescribed by their individual surgeon.
- Dietetic input was on request for patients requiring naso-gastric (NG), percutaneous endoscopic gastrostomy (PEG) or total parental nutrition (TPN) intravenous feeding. The unit had a small stock of NG or PEG feeding solutions. Intravenous solutions were prescribed and delivered from Lincoln County hospital within 24 hours.
- There was no routine swallowing assessment, prior to commencement of oral intake, for patients with tracheostomies or following long-term intubation (artificial airway). This meant there was a risk of aspiration (inhalation of fluids) for these patients. We were told staff gave patients sips of water initially to establish if they could swallow effectively. Assessment by a speech and language specialist team (SALT) could be requested if they were concerned about a patient's ability to swallow. However, there was limited provision of SALT within Pilgrim hospital.

Patient outcomes

- The Intensive Care National Audit Research Centre (ICNARC) data meant outcomes of care could be benchmarked against similar units in England. A data clerk was employed to collect and submit data.

Critical care

- Data provide by the critical care unit for the period 1st April 2015 to 31st March 2016 showed there had been 519 admissions. Of these 465 (89%) survived and 54 (10%) had died. This outcome was better than other units of a similar size. Intensive care national audit and research centre (ICNARC) data reported a calculated mortality (death rate) ratio 0.85 per 500 patients with other similar units ranging from 0.9 to 1.3 per 500 patients.
- Critical care had a local audit programme, which listed active and completed audits, the audit title and a named consultant lead. At the time of our inspection, there was three active audits. Acute kidney injury in major bowel surgery, reducing blood loss on intensive care through sampling and targeted temperature management following cardiac arrest.
- Information provided by the trust, in the form of incident reporting data, identified a high rate of delayed discharges from critical care. This was particularly for medical patients and was attributed to limited bed capacity and a reluctance of medical consultants to take over responsibility for patients admitted directly to critical care under a named intensivists. However, in response to a request for a breakdown of delayed discharges by speciality, the unit informed the inspection team, they did not collect this data. We were therefore unable to confirm this information.
- We attended a bed management meeting where senior nurses are informed of patients ready for transfer out of critical care.

Competent staff

- A band seven-nurse educator supported registered nurses in their professional development. All registered nurses working on the critical care unit attended a three part educational programme to develop their critical care skills at various time intervals, for example, part three of the course was for nurses with two years' experience and matched the university critical care module.
- There was limited access to university based critical care modules with funding for three nurses per year. At the time of our inspection, 38% of registered nurses on the unit had completed the post registration critical care module which did not meet the required 50% of registered nursing staff being in possession of a post registration award in critical care nursing. However, three nurses were due to complete the modules in the month of our inspection and a further three places had been secured for the next scheduled course. The professional development nurse was aware of this shortfall and mitigated this through ensuring each registered nurse completed the three part in-house training.
- Medical and nursing staff were on a rolling programme of appraisals. Information provided by the department showed medical staff at 100% compliance and nursing staff at 66% compliance. Staff without completed appraisals had dates to attend; these were displayed in the senior nurse's office. Trust target for staff appraisals was 95%.
- The majority of staff told us objectives set at their appraisal were meaningful, achievable and reflected the trust values.
- Nurses were being offered individual assistance with their revalidation requirements. Information related to nurse revalidation was in the staff rest room.
- Training and development was discussed at staff meetings, evidence of this was seen in meeting minutes, which were available in the staff rest room.
- Technicians working within critical care were fully qualified operating department practitioners (ODP) and provided training in safe patient transfer for nursing and medical staff.
- Junior and trainee doctors told us they had appropriate practical training opportunities and good supervision.

Multidisciplinary working

- There was an established multidisciplinary handover each morning attended by consultants, junior medical staff, physiotherapy, nursing staff and critical care outreach. We observed this to be comprehensive with open discussion and clear individual patient treatment planning. All plans were recorded onto the electronic patient record system.
- A pharmacist attended the critical care unit daily. However, there was not adequate pharmacist provision to meet the intensive care core standards, which states there must be a critical care pharmacist for every critical care unit. This meant pharmacy was unable to attend multidisciplinary ward rounds.
- There was limited dietetic input for patients on the critical care unit and no dietician attendance to multi-disciplinary meetings. However, input was available on request.

- Microbiology advice was available by telephone. Attendance at multidisciplinary meetings was not possible due to limited resources trust wide.
- Critical care outreach team (CCOT) was available 24 hours. A senior nurse from the CCOT attended the critical care multidisciplinary morning handover and provided support for patient planned discharges.
- As part of the MTCCN, the unit benefited from the multi-professional input from other units within the network. This was essential for continuity and consistency of care when transferring patients to other units for specialist care.
- There was an established multidisciplinary discharge process with clear medical and nursing documentation. However, the unit had difficulties establishing medical teams to take over the care of medical patients admitted to critical care under named intensivists.
- An electronic summary of treatment and care was generated and sent to the patients' general practitioner (GP) following discharge from the unit.

Seven-day services

- The critical care unit had medical and nursing rotas providing 24-hour cover seven days a week. This enabled the unit to meet the NHS services, seven days a week, priority clinical standards.
- All emergency admissions were clinically assessed within 14 hours of admission and all patients were reviewed twice daily however, we were informed the unit experienced delays in access to some medical tests at a weekend. These included echocardiography (Scan of the heart) and ultrasound (a diagnostic imaging technique).
- Physiotherapy provision was seven days a week with on-call cover at night.
- Pharmacy visited the unit six days a week with on call provision out of hours and Sundays.
- Microbiology was available on an on-call basis seven days per week.

Access to information

- Staff did not report any problems with access to patient information.
- There was a formal handover document for patients being transferred out of critical care. This met the national institute of clinical excellence recommendations and had been developed in conjunction with the MTCCN.
- Information to support the care and treatment of patients was readily available through the bedside electronic system.
- There was information for visitors within the visitor waiting area and they were provided with a booklet explaining about critical care, which included a direct line telephone number to avoid delay in getting through to the unit.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Patient's mental capacity was assessed on admission to critical care and reassessed at periods throughout their stay.
- Mental capacity training was part of mandatory training.
- Staff were able to demonstrate to us they had a clear understanding of the mental capcity act and the deprivation of liberty safeguards.
- We observed medical and nursing staff gaining verbal consent prior to any interventions and where appropriate involving family in assisting patients with decisions.
- The critical care unit had a sedation policy and each patient's sedation status was reviewed as part of their daily treatment planning.

Are critical care services caring?

Good

We rated critical care as good for caring because:

- Patients were treated with dignity, respect and compassion during all observed interactions between staff and patients.
- Feedback from patients and carers was consistently positive.
- Family and friends were informed of progress and appropriately encouraged to be involved in the care provided.
- There were follow up support clinics for patients who had received level three critical care.

However we also found:-

- Some visitors found the restricted visiting hours did not meet their individual needs.

Compassionate care

Critical care

- During the inspection, we observed patients treated with dignity and respect. Curtains were drawn and signs indicating personal care in progress were clearly visible. We saw staff requesting permission to enter bed spaces when the curtains were drawn.
- Staff interacted with patients in a positive way, explaining each intervention prior to touching them. For example taking an observation or repositioning them in bed.
- Patients, who were able, were encouraged to sit out of bed in a chair. One patient told us 'I didn't expect to be able to get out of bed so soon; it makes me feel much better'.
- During visiting time, we observed effort to give patients and their visitor's privacy whilst remaining available to answer any questions or concerns.
- We observed visitors provided with information about the unit and told how they could contact through a direct call to the patient's bedside.

Understanding and involvement of patients and those close to them

- We observed patients and those close to them involved in discussions about their care plan including what to expect during the recovery process. This included reassurance about support provided once transferred to a ward.
- There was set visiting times for family and friends. One visitor told us it was difficult to fit visiting in around other commitments, this meant, on occasions they were unable to visit. However, all patients had visitors on the days of our inspection and staff told us they were flexible to meet visitor and patient needs.
- Patients told us it was noisy at night. Although nurses said, the lights were dimmed and staff tried to keep the noise to a minimum to promote a normal night and day cycle.

Emotional support

- We observed staff providing emotional support to both patients and visitors, explaining what was happening and answering their questions openly and honestly.
- A hospital chaplain was available 24 hours a day. One chaplain told us they visit each department every day to see if patients or their loved ones needed their support.
- Patient diaries had recently been introduced to document patient's daily activities. The purpose of these was to provide a record of their time in critical care. This helps patients with their post-critical care recovery as this was often a period, which they find difficult to remember, or was muddled.

Are critical care services responsive?

Good

We rated critical care as good for responsive because:

- The critical care met the needs of the population and worked flexibly with other services within the trust to maximise effective use of beds.
- Individual needs were met through staff responding and adapting their approach to each patient's needs.
- Early rehabilitation of patients through the employment of a physiotherapy assistant was in place within critical care.

However we also found:-

- There was a high level of delayed discharges for medical patients.
- There was no documentary evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- The critical care unit admitted elective (booked) and emergency patients. The unit was funded for nine beds, which were used flexibly to provide level three or level two care.
- There were two isolation rooms located within the critical care department, but separated from the main unit by a corridor and the nurse's station. These rooms were not routinely used by critical care because of their isolated location in relation to the main unit.
- Earlier in 2016, there had been a trial period of utilising the two rooms for level one (post-surgical) colorectal cancer patients. This had proved to be successful in the support of the local colorectal service. It was agreed for this to be a permanent arrangement managed and staffed by the surgical business group. However, we were assured this facility could be reintegrated into critical care as a priority if required. This demonstrated flexible working with other services within the trust to maximise effective use of available beds.

- The unit was working to Mid Trent Critical Care Network (MTCCN) guidelines and protocols when planning service developments and utilised the MTCCN admission, transfer and discharge policies to ensure consistency of critical care provision within the network group of hospitals.
- Critical care held multidisciplinary follow up clinics for patients who had received level three care. These included access to consultant, nursing, dietician and physiotherapy personnel to help patients adjust following a critical illness and offer an opportunity for patients to discuss physical, emotional, or psychological concerns they had following discharge.
- There was a basic overnight facility available on the unit for visitors who had travelled long distances or when a patient was critically ill. Additionally there was a private facility, within the hospital grounds, where visitors could stay overnight at reasonable cost.

Meeting people's individual needs

- The critical care unit engaged with patients, carers and specialist nurses when providing care to people living with complex needs. We observed staff responding and adapting their approach to patients according to their individual needs. For example encouraging carer involvement in care planning. We reviewed care plans for patients present on the critical care unit during our inspection and found their care plans included reference to discussions with patients, family or carers, which indicated an awareness of patient preferences. For example food preferences or listening to music.
- The critical care unit had recently introduced patient diaries as a personal record of an individual's stay on the unit. This was to assist with patient's long-term rehabilitation by recording daily activities, which they may have no memory of due to the severity of their illness or as a result of the sedation given.
- There was access to a commercial telephone language line to provide translation for patients who did not speak English. Staff on the unit told us they knew how to access this service and had used it. They also told us, on occasions, staff within the hospital assisted with translation. Staff told us family and friends were not routinely used for translation.
- The critical care unit had facilities, including hoists, to enable them to care for the larger patient. Additional equipment, such as larger chairs, could be accessed through the manual handing department.
- The hospital had a named contact for support when a patient was admitted with learning difficulties.

Access and flow

- ICNARC data for the same period included the number of patients transferred to other critical care units for non-clinical reasons, for example to create bed capacity. This was 1% of all admissions, which was equal to similar sized units who provide such data within England. Current evidence and guidance indicates patients transferred to other Critical care units for the same type and level of care spend longer in hospital overall and have poorer outcomes.
- Unplanned readmissions (patients returning to critical care within 48 hours of discharge to a ward) was 1% of all admissions. This was similar to other critical care units where on average readmission was 0.8%.
- The percentage of bed days occupied by patients with delayed discharges of over eight hours was 4%. This compared to the national average of 5%.
- The percentage of out of hour's discharges, between 10pm and 7am, was 3% of total discharges to the ward this was within the expected range for a unit of this size.
- Medical and nursing staff expressed concerns about delays in discharging medical patients. Emergency medical patients were admitted into the unit under the care of a named critical care consultant. Difficulties were encountered trying to identify a suitable medical consultant to take over care. This resulted in delayed discharges. Staff told us of delays of up to 72 hours and occasionally patients were discharged home from the unit. However, data relating to reasons for delayed discharges, by speciality was not collected.
- During the period April to June 2016 there was 73 elective (planned) operations, with a planned stay on critical care, cancelled. Ten of these were due to a lack of critical care bed. others were cancelled for non-critical care related reasons.
- Critical care is situated on the same floor as the hospital operating theatres. Staff told us, on rare occasions, patients are cared for in the recovery area whilst a bed is made available on the unit.

Learning from complaints and concerns

- Senior nursing staff told us they encouraged all staff, wherever possible, to resolve concerns raised directly with the people concerned. However, if they were

unable to do so the person would be provided with information on how to contact the patient advice and liaison (PALS) service. This information was displayed in the visitor's room.
- Concerns raised were discussed at staff meetings. We saw meeting minutes, which included a brief description of any complaint received and an update on the response process. However, there were very few complaints and there were no lessons learnt included in the minutes we reviewed.
- All complaints trust wide, were collated centrally into a patient experience report, which was presented to Trust Board. Data provided by the trust showed one formal complaint received for critical care at Pilgrim Hospital related to standard of care received.

Are critical care services well-led?

Good

We rated critical care as good for well-led because

- There was an established and effective governance framework in place. We saw evidence within the minutes of trust wide intensive care meetings where quality and safety topics were discussed. This included staffing levels, complaints, incidents, mortality and morbidity and an update on the critical care risk registers. Each topic had actions with a named individual with responsibility.
- Leadership was provided by an appropriately trained and experience clinical director, supported by a senior nursing team.
- Staff at all levels within critical care told us there was a positive culture and they were happy to be working in the department.
- Staff knew the management structure and felt empowered to report any concerns they had to a senior member of staff. They were confident they would be listened to and appropriate action taken.
- The critical care unit held an annual patient feedback event.

However we also found:-

- There was no clear vision for the critical care service.
- Critical care outreach did not benefit from the management or leadership of the critical care department.

Vision and strategy for this service

- There was not a five-year plan for the critical care unit or a clear vision for the service. However, the senior team told us they felt very proud of how the team worked together and supported each other. They expressed a wish to increase provision by opening an additional fully funded bed.
- As a member of the mid Trent, critical care network (MTCCN) the departments plans for development was closely linked to the MTCCN annual review, which identifies areas for improvement and cross network sharing of best practice. The MTCCN annual review enables units to identify and prioritise future work-streams for improvement. For example, a recommendation was for all critical care units within the network to have daily ward rounds, which included input from nursing, microbiology, pharmacy, physiotherapy and dietetics. Pilgrim critical care was unable to meet this recommendation due to a lack of local specialist resources.

Governance, risk management and quality measurement

- Critical care had a framework in place through which the department was able to identify, understand and address risk. We saw evidence within the minutes of trust wide intensive care meetings where quality and safety topics were discussed. This included staffing levels, complaints, incidents, mortality and morbidity and an update on the critical care risk registers. Each topic had actions with a named individual with responsibility.
- The clinical lead reported critical care issues to trust wide governance meetings.
- Senior critical care nurses updated staff at regular unit meetings. Minutes were accessible to all staff both electronically and in files within the staff rest room.
- The critical care risk register included an identified need for replacement ventilators (artificial respiratory support) for which the unit was in the process of undertaking trials to determine the model of choice.

Leadership of service

Critical care

- There was a Clinical Director and lead anaesthetic consultant for the critical care unit. All critical intensive care consultants were suitable qualified and experienced.
- There was a matron with overall responsibility for the critical care, supported by two senior nurses who worked together with each having specific responsibilities for areas of management.
- Staff were positive about the leadership of the department. There was an acceptance of different personalities and management styles at senior level, which complimented each other.
- Staff told us they felt appreciated and supported to undertake their role effectively.
- The unit had been through an unsettled period following a concern raised about management styles. An investigation had been conducted and an action plan agreed. This included attendance at a series of leadership development sessions. We saw dates were agreed for these sessions over the forthcoming weeks and senior staff were confident about the future stability of the unit.
- Each shift within critical care had a designated supernumerary clinical coordinator in accordance with intensive care core standard requirement.
- CCOT did not benefit from specialist critical care consultant leadership. The service was not under the direct management of critical care and the senior CCOT nurse expressed concerns that there was a lack of specialist consultant clinical leadership for this service. However, the team worked alongside the critical care team and were able to support patients discharged to the ward.
- The CCOT team worked alongside other hospital inpatient support services, including hospital at night, clinical support and nerve centre, providing education and assistance with caring for patients The CCOT service was under considerable pressure with up to 250 referrals per month.

Culture within the service

- Staff at all levels within critical care told us there was a positive culture and they were happy to be working in the department.
- Staff knew the management structure and felt empowered to report any concerns they had to a senior member of staff. They were confident they would be listened to and appropriate action taken.
- There was understanding of the term duty of candour and staff told us they would always be open and honest with patients.
- We observed staff working together collaboratively to provide care for patients and to support each other in their working day.

Public and staff engagement

- The critical care department held an annual patient and carer feedback event. There was an event planned for the week following our inspection with a predicted attendance of up to 15 people. Patients who had attended in previous years had provided feedback on their experiences. This had included noise levels during the night.
- Patient and carer feedback was included in ward team minutes for example reminding staff to be mindful of noise levels at all times and to consider how this could be kept to a minimum at night.
- The unit did not take part in family and friends test. However, the patient experience team was provided with copies of correspondence received in the form of cards or letters. These were counted and the numbers received displayed under the heading 'counting compliments'.
- Staff were actively involved in the annual patient feedback event.

Innovation, improvement and sustainability

- Patient diaries were completed for patients who had been cared for at level three. These were completed each day and given to patients when they discharged from the unit. The information helped patients to understand what had happened to them during their stay on the unit, which was often confused due to the effects of sedation.
- The critical care department had been active in supporting the plan to use the two side rooms to care for colorectal cancer patients. This was following a successful pilot earlier in the year.

Maternity and gynaecology

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

Information about the service

Maternity and gynaecology services provided by United Lincolnshire Hospitals NHS Trust (ULHT) are located on three hospital sites, Lincoln County Hospital, Pilgrim Hospital Boston and Grantham and District Hospital. Services at Pilgrim Hospital are reported on separately however, services on the two hospital sites are run by one maternity and gynaecology management team. They are regarded within, and reported upon by the trust as one service, with some of the staff working across the two sites. Policies and procedures reported on were trust wide. For this reason, it is inevitable that there is some duplication contained in the two reports. Where possible the trust has separated the data for the purpose of inspection.

Maternity services at Pilgrim Hospital included antenatal clinic, antenatal assessment centre, maternity ward (M1) consists of 18 beds in four bedded bays with six side rooms. Labour ward has eight rooms, one of which includes a birthing pool, two theatres and a recovery area.

Between April 2015 and March 2016,

2,058 births occurred in Pilgrim Hospital.

The gynaecology ward (M2) is currently situated on the second floor within the maternity block and has 16 beds divided into three four bedded bays and four side rooms. Outpatient colposcopy, hysteroscopy, early pregnancy unit and emergency gynaecology referrals has three couches within the ward for women's services.

Three community midwife teams covered Spalding, Boston and Skegness providing maternity services, including homebirth, antenatal and postnatal care over a large geographical area. Teams worked in partnership with GPs, health visitors and children's centres providing lifestyle support and advice to women and families during pregnancy and following the birth.

During our inspection, we visited all ward areas and departments relevant to the service. We spoke with nine women, four relatives, and 19 members of staff including; senior managers, service leads, managers, midwives, consultants, doctors, nurses, anaesthetists, sonographers, support workers, administrators and domestics. A further 14 members of staff attended cross site focus groups. We reviewed nine sets of medical records.

Maternity and gynaecology

Summary of findings

We rated this service as requiring improvement because:

- Many of the audits did not provide plans for presentation of findings to colleagues or current timelines.
- Not all staff supporting women undergoing termination of pregnancy had approved counselling qualifications.
- Staff had not received recovery update training.
- The unit struggled to gain feedback from the non-English speaking population.
- Maternal choice for a midwife led unit delivery was limited.
- There were no designated bereavement areas for families who had lost a baby.
- The gynaecology ward often included non-gynaecology patients.
- The labour ward recovery area was not set up for use or in a private room.
- Data collection was not robust due to discrepancies in collection.

However, we also found:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Lessons were learned and communicated to staff.
- Clinical areas were visibly clean and attempts were made to improve the working environment.
- Safeguarding support for staff had increased with the introduction of specialist midwives.
- Women's care and treatment was planned and delivered in line with current evidence based guidance.
- Staff gained consent prior to all care and treatment, including for disposal of fetal remains.
- Staff received appraisals and were supported in training with practice development staff.
- Staff responded compassionately and families were treated with kindness and respect.
- The increase in number of specialist midwives would give support to areas such as bereavement and governance.
- Women were aware of how to complain and their complaints were taken seriously.
- The women's and children's service was driven by quality. Despite an unknown future short term changes were performed to improve services for women.
- Governance structures functioned effectively and interacted appropriately.
- Teamwork throughout the hospital was apparent and staff felt they were listened to.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

We rated safe as good because:

- Within maternity, staff were aware of their responsibilities around identifying around reporting incidents.
- Clinical areas were visibly clean although in need of modernising in places. Water taps were flushed in line with safety recommendations.
- Medicines were stored securely in line with recommendations.
- Safeguarding documentation was robust and information sharing effective. Safeguarding training was provided at level three for most staff.
- Asbestos had been removed and attempts made to improve the environment in maternity and gynaecology.
- Risk assessments were completed within patient records.
- WHO checklist audit demonstrated 100% compliance.
- Staffing levels and skill mix were planned and reviewed to maintain safe staffing levels.

However, we also found:

- Within gynaecology, staff did not have a clear understanding of the incident investigation process.
- We did not see documentation of actions around the duty of candour.
- Presentations by the mortality and morbidity committee were not shared with the rest of the service.
- Safety dashboard information was not routinely displayed and historically data was considered inaccurate. Data collected was inconsistent and not red, amber and green rated, or utilised to the greatest advantage.
- Completion rates for infection prevention and control training were between 59% and 83%.
- Adult basic life support training was between 48% and 63%.
- We did not see evidence of a daily safety huddle performed to share information on the sickest most at risk women or pressures across the units.

Incidents

- All staff we spoke with understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses on the hospital electronic reporting system. Although, the experience of this in gynaecology was limited.
- There were 781 incidents reported for maternity and gynaecology between July 2015 and June 2016. Three incidents were classified as 'severe risk' and 24 as a 'moderate risk' Data supplied by the trust could not be separated to identify which incidents related to gynaecology only. The reporting of incidents was not as embedded within gynaecology and staff did not have an awareness of recent incidents or the investigation process.
- Between August 2015 and July 2016 the trust reported no incidents which were classified as never events for maternity and gynaecology.
- Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Weekly multidisciplinary IR2 (incident management reports stage 2) meetings occurred. Action reports had been completed following a review of each incident, and learning was shared with staff via minutes. Supervisors of Midwives (SoMs) were not always present, but if investigations identified practice issues SoMs performed independent investigations and action plans.
- The risk management midwives told us they were working with staff on the principles of incident grading. This included raising awareness of incident reporting and investigations for the gynaecology nurses.
- In a recent attempt to increase staff awareness of incidents they were included in the Women's and Children's Midwifery and Nursing newsletter sent to all staff and placed in ward areas. The awareness of staff of the newsletter and feedback was limited. We saw them displayed in staff areas.
- Risk team members and matrons read all moderate and severe incidents on a daily basis. Sometimes the severity of harm was altered at this point. A clear process to follow was laid out in the risk strategy with clear definition of roles and responsibilities.

- Staff were able to give examples of changes in relation to incidents, such as referring all women who book late in their pregnancy for a consultant review and using language line for all ladies for whom English is not their first language.
- A perinatal and maternal mortality and morbidity presentation was held monthly and involved multidisciplinary team members (MDT). All cases presented by the medical staff had been through the risk management process. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. We reviewed the presentations from two of these meetings in May and July 2016 and saw that staff reviewed cases in detail, with areas of good practice highlighted, together with learning outcomes. These outcomes were not shared further than those attending the presentation.
- 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 women (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust had a duty of candour policy, and senior staff had a comprehensive understanding of this. Staff spoke about telling people when an incident or near miss had occurred. We reviewed IR2 minute meetings that contained actions but did not include duty of candour recommendations. Managers discussed cases where families were involved in creating information for parents following a bereavement.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at patient harms such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections. Maternity and gynaecology services took part in this scheme. Data for this was collected on an identified day each month to indicate performance in key safety issues. Each ward displayed data around harm free care at the entrance to each ward area. Maternity services reported 100% harm free care, and gynaecology reported 85% harm free care for September 2016. The significance of this was not explained to women and visitors.
- The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. This is a system of reporting on harm free care. The recommended areas of harm which have occurred included; perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from the baby and psychological safety. Also included were admissions to neonatal units, and babies having an apgar score of less than seven at five minutes. (the apgar score is an assessment of overall new-born well-being).This is a system of reporting on harm free care specific to maternity services. The maternity service tooj part in the national maternity safety thermometer.
- Staff completed a modified dashboard of information stating the percentages of events, including the maternity safety thermometer events. However, these were not RAG (red, amber, green) rated on the data provided by the trust. This meant they were not able to monitor their harm free care rates. The hospital did not have an electronic recording system for data, staff told us this led to unreliable data. The dashboard was combined trust wide and displayed across the unit. Senior staff were unfamiliar with the data collected on the dashboard. A new RAG rated dashboard was in development. This was discussed at speciality governance meetings.

Cleanliness, infection control and hygiene

- The clinical areas we inspected were visibly clean. A programme of refurbishment had been completed in ward areas. Flooring had been replaced and was intact and wipe clean.
- Programmes of cleaning and audits were in place in all areas. Cleanliness scores around maternity and gynaecology were 90% to 93%, this was slightly below the trust target of 100%. There were hand gel dispensers on entry to all clinical areas and also at the point of care. Signage regarding hand washing for staff and visitors was on display and we observed staff using the gel appropriately. Hand gel outside ward areas had been removed due to theft although signage still existed.
- The hospital's bare below the elbow policy for best hygiene practice was adhered to. Staff had access to, and were seen to use personal protective equipment such as gloves and aprons.
- All wards and departments carried out hand hygiene audits every month. The audit looked at the World

Health Organisation (WHO) five moments for hand hygiene. The audit focuses on five moments when hand hygiene should take place. These are, before patient contact, before undertaking a clean or aseptic procedure, following an exposure risk, after patient contact and after contact with a patient's surroundings. Between January 2016 and June 2016 maternity and gynaecology achieved 86% to 96% compliance in the audits. Hand hygiene awareness initiatives included drop in and roadshow sessions trust wide, four monthly hand hygiene awareness weeks and the use of online training videos. Maternity audits for July 2016 achieved 100% compliance.

- Equipment had 'I am clean' stickers on them. These were visible and documented the last date and time they had been cleaned. This meant staff knew the equipment was clean and ready for use.
- There were reliable systems in place for the management and disposal of clinical waste and sharps in accordance with the trust policy.
- The trust reported no cases of MRSA bacteraemia, Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemia or Clostridium difficile (C. difficile) infection for maternity and gynaecology services for the reporting period April to July 2016. MRSA is a bacterium responsible for several difficult-to-treat infections. MSSA differs from MRSA due to antibiotic resistance. C. difficile is an infective bacteria that causes diarrhoea, and can make people very ill and is associated with antibiotic usage.
- The hospital reported and investigated all readmissions for surgical site infections. In gynaecology between July 2015 and June 2016 the hospital reported six episodes of surgical site infection, none of these involved readmission of the patient.
- Staff accessed mandatory infection prevention control training through an e-learning package. The average compliance for staff across the trust was 74%. This was worse than the trust target of 95%. The compliance rate for medical staff was 79%, and data showed 83% of maternity and 59% of gynaecology staff had completed IPC online training.
- In accordance with Health and Safety Executive (HSE) managing Legionella guidance all ward taps had a suitable filter and taps were flushed daily. We saw documentation to confirm that this was completed by nominated staff throughout the unit.
- However between April 2016 and July 2016, 28 episodes of Legionella were detected in the weekly samples. Actions were taken to reduce patient contamination. We saw evidence of discussions held to clean the water systems and minimise the risks of Legionella. Such actions included raising the water temperature overnight, and strip, clean and disinfect taps, pipework and mixing valves. The trust placed filters on the taps, monitored water temperature and will be moving the ward to the new modular build by the end of the year. Plumbing staff attended training sessions on legionella awareness courses. Since August 2016 and the corrective actions, only one positive result has occurred during weekly testing.

Environment and equipment

- Doors to gain entry to the ward areas were locked and staff gained entry and exit via a swipe card system. CCTV cameras were in use in all areas. Reception staff assisted during busier times by answering the door. An abduction policy was in place, although staff could not recall performing an abduction exercise drill. All staff we spoke with were aware of the actions to take.
- Work had been completed on wards M1 and M2 to improve the environment. Previous asbestos had been removed, ceiling painted and the ward felt bright and welcoming. The flooring and windows had been replaced and murals placed at the end of corridors. M2 ward was waiting for a move to a new ward area later this year. The ward would be smaller with dedicated couches for early pregnancy clinic, colposcopy services, hysteroscopy and emergency ward attenders.
- Within labour ward the emergency equipment checking system required signatures in multiple places. Some of the documents had gaps for checks performed. The overall signature sheet for the ward was complete. Staff told us they checked each resuscitaire (a warming platform used for clinical emergencies and resuscitation) before use. We checked four partogramms (labouring women's notes) and the resuscitaire check box had been completed. No incidents had been reported of resuscitaires being unfit for use. We observed that equipment and consumables stored on the resuscitation trollies were sterile and within their expiry date. This meant safety equipment was readily available in the event of an emergency.
- Checking of emergency equipment in the antenatal day assessment unit (ADU) was inconsistent. From May 2016

to September 2016, signatures were missing for approximately 39% of the days on which the unit was opened. This was highlighted to staff in the unit. The staff in ADU used manual blood pressure machines in line with guidance, however if a series of blood pressures were required every five minutes no automated blood pressure machine was available. This was not poor practice, but would limit the possible tasks a midwife could perform accurately. It is possible to perform the mean arterial pressure (MAP) manually, but would have been performed automatically by a machine. Trust guidance stated 'MAP could be useful additional information when making the decision on whether to treat with anti-hypertensives'.

- Clinic and ADU staff did not have automated urinalysis machines for performing clinical urinalysis. This was not in line with NICE guidance CG107 for the assessment of proteinuria in hypertensive disorders in pregnancy.
- Within wards M1, M2 and clinics areas in both maternity and gynaecology, emergency equipment was checked consistently, with items appropriately packaged, stored and ready for use. All equipment we looked at had been routinely checked for safety with visible safety stickers demonstrating when the equipment was next due for service. This included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Staff were aware of the process for reporting faulty equipment.
- Most staff told us that adequate equipment was available to run the service safely. We looked at cardiotocography (CTG) equipment on the delivery suite. CTG equipment is used to monitor a baby's heart rate and a mother's contractions while the baby is in the uterus. The CTG equipment we looked at was clean and had been checked and labelled when the date of the next maintenance check was due.
- Staff told us they did not have a waterproof 'telemetry' CTG machine for use in labour. The telemetry machine enables greater movement for the women and monitoring of the fetal heart in the birthing pool. Staff also commented that during clinics locating hand held dopplars, for listening to a fetal heartbeat, was time consuming due to a limited supply.
- There were pool evacuation nets for water birth evacuation in the pool room on the Labour Ward. Staff signed a document within the pool room to confirm they had received pool evacuation training.
- Storage facilities throughout the department were limited, and trollies and equipment was stored in a parallel corridor, which did not appear to compromise access.
- Despite labour ward being a consultant led ward, every attempt had been made to make two of the rooms welcoming and a home from home environment. Low 'mood' lighting was permanently used, and when the room was not in use the door was open for women to see.

Medicines

- Medicines were managed, stored and administered appropriately. Controlled drugs (CDs) were stored appropriately in all of the clinical areas we inspected. CDs are medicines which have extra security controls over them. They are stored in a separate cupboard and their use recorded in a CD register.
- We checked medication cupboards and ward trolleys. Intravenous fluids were stored in locked rooms in most areas and fridges used to store medicines were locked, which meant they were protected from the risk of being tampered with. On the labour ward the intravenous fluids were kept in a room with a door but no lock, this was in a non-public area. The clinical drug preparation area on Labour ward was situated in an alcove on the public corridor, however, this included locked drug cupboards. Staff told us disturbance was rare, but the area did not allow staff to prepare and check medications in an undisturbed area.
- Fridges were checked and temperatures recorded daily. Staff on M2 ward had recorded temperatures outside the normal range for a few days before senior staff became aware of this. Pharmacy was informed and the appropriate action taken with refrigerated items.
- Emergency drugs for a post partum haemorrhage (severe bleed after birth) stored in the fridge were not in an easy to grab box. Staff discussed this with Lincoln County Hospital and placed drugs in a box within the fridge to speed up the response to an emergency.
- The hospital used paper prescription and medication administration charts for women. A pharmacist checked medicine prescription charts, and the checks recorded in green ink on the prescription charts to help guide staff in the safe administration of medicines.
- We saw appropriate arrangements were in place for recording the administration of medicines. The records

were clear and fully completed. The records showed women were getting medicines when they needed them, and any reasons for not giving women their medicines were recorded. This meant women were receiving their medicines as prescribed. If women were allergic to any medicines this was recorded on their prescription chart.

- Within the termination of pregnancy service, a doctor prescribed all abortifacient medicines. We saw that drugs that induced abortion were only prescribed for women undergoing medical abortion following completion of a face-to-face consultation with a member of the nursing team, written consent and completion of the HSA1 (grounds for carrying out and abortion) form signed by two doctors.

Records

- Patient care records were in paper format and used trust wide. Staff stored medical records securely in restricted areas or in lockable trolleys in clinical areas in line with data protection policies.
- Women using the maternity service were provided with their own set of hand held care records to bring into the hospital with them. The hospital also held medical records relating to each woman. Staff told us notes were readily available throughout pregnancy and for planned gynaecological admissions. However, notes were often large with loose pages that could fall from the folder and become lost.
- On ward M2 we saw records from patient admissions which were awaiting main notes that had not come during the patient admission. Staff told us that finding notes for inwomen on ward M2 was made worse by the high number of women who were not gynaecology women.
- Child health records known as 'red books' were given to mothers for each new born baby following the completion of newborn and infant physical examinations.
- Midwives performed maternity records audits in conjunction with supervisory interviews and mandatory training. This included learning actions such as accurately documenting in notes CTG classification every hour. Between April 2016 and June 2016, 42% of records reviewed did not include required data. This included the date, time and signature of reviewing practitioner on the tracing if there was any deviation from the classification of 'normal'. In the same period, all notes lacked documentation of management plans and appropriate actions taken if care deviated from the normal path. The audit included 16 sets of records.
- All ward staff completed an SBAR form (situation, background, assessment, recommendation) to handover information. This ensured information given was clear concise and relevant. This was signed on each handover of care.
- The postnatal notes included risk assessments for the community midwives and gave concise information from the pregnancy.
- We reviewed nine sets of notes throughout maternity and gynaecology, the named midwife or nurse leading the women's care was documented. Records were legible, dated and signed with clear plans of care. All records were multidisciplinary and we saw where nurses, midwives, doctors and allied health professionals including physiotherapists had made entries. Care plans for women undergoing an elective caesarean section were loose leaf; this could lead to an inconsistency of documentation included.
- Risks to women, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools incorporated into care plans.
- Staff on labour ward had, worked hard to simplify the pregnancy loss paperwork and bereavement process. This meant that staff had more time to support families and the risk of families having to return to sign forgotten paperwork would be reduced..

Safeguarding

- The Head of Midwifery and Nursing was the named midwife for safeguarding. The trust had recently appointed a named safeguarding lead for maternity across the two sites. The specialist midwife worked Monday to Friday from 9am to 5pm.
- Staff we spoke with knew about the trust's safeguarding process and were clear about their responsibilities. Many had experience of safeguarding incidents and felt supported in practice.
- Display boards around the ward areas gave comprehensive information on safeguarding including Deprivation of Liberty Safeguards and the Mental Capacity Act information. Contact numbers were visible to staff for further support.

- Intercollegiate document 2014 states that all clinical staff working with children, and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child, where there are safeguarding concerns should have level three training. Training data received during the inspection identified that 84% of staff in the womens and childrens business unit had received level three training. This was worse than the trust target of 95% and did not meet intercollegiate guidance. Training included advice on female genital mutilation (FGM is the practice, traditional in some cultures, of partially or totally removing the external genitalia of girls and young women for non-medical reasons.) and child sexual exploitation (a type of sexual abuse). This training was provided for all grades of clinical staff.
- Staff within the termination of pregnancy clinic understood their responsibilities including referring to social services young women under the age of 16 and speaking to women alone to establish there were no risks of coercion.
- The electronic safeguarding database had improved communication of concerns and plans. Staff were able to check throughout the hospital if safeguarding plans were in place. We saw evidence of this working well and staff updating both paper and electronic records.
- The FGM guidelines were tailored around the mechanisms of FGM and did not refer to safeguarding, which is not in line with Department of Health May 2016 guidance. Staff told us that the guidelines have recently been amended to incorporate this, but were not yet ratified.
- Safeguarding supervision had recently improved to a more formal system. This was due to be performed every three months.

Mandatory training

- Mandatory training included moving and handling, infection prevention, equality and diversity, information governance, conflict resolution, basic life support and safeguarding vulnerable adults and children. Safeguarding training was provided at an appropriate level depending on the requirements of the staff group.
- Data provided by the trust demonstrated that hospital compliance across women and children's services for mandatory training for staff was 87%, although trust basic life support training for doctors was at 48%. Nursing and healthcare compliance for adult basic life support was between 48% and 93%. The hospital did not meet the target (95%) for all staff groups in nine out of ten courses.
- Maternity staff described attending yearly skills and drills training. This included; maternal and neonatal resuscitation, electronic fetal monitoring, management of obstetric emergencies, recognition of the severely ill pregnant woman, sepsis training, manual optimising normal birth, antenatal and newborn screening, infant feeding, diabetes and weight management. Unfortunately these were not yet multidisciplinary at Pilgrim Hospital due to insufficient medical facilitators. Maternity data for June 2016 demonstrated 93% of midwives had attended this training. A total of 43% of medical staff had attended the training despite the lack of practical sessions for all scenarios. Practical skills and drills sessions were not performed every week at Pilgrim Hospital due to the unfilled post of maternity clinical educator.

Assessing and responding to patient risk

- Staff on ward M2 completed comprehensive risk assessment care plans for all women. These include national early warning scores (NEWS, used to assess the health and wellbeing of women who were identified as being at risk), malnutrition universal screening tool (used to identify adults at risk of malnutrition), and pressure ulcer assessments. The care plans included details in continuing care, such as fluid balance charts, catheter management and cannula care. A sepsis screening tool was also included in the booklet, with a sepsis six prompt for escalation purposes.
- Maternity care plans were in a booklet form which could be increased in the event of obstetric emergency. The Maternal Early Warning Score (MEWS) was used to assess the health and wellbeing of women who were identified as being at risk. We observed appropriate escalation of a woman's condition due to a rise in the MEWS score. We checked nine sets of notes and found these had been completed and scores were calculated. The hospital staff completed observation assessments, on newborn infants using the neonatal early warning scores.

- Babies undergoing newborn observations were cared for on transitional care (an area of the ward where babies requiring a higher level of care are looked after with their mothers) on M1, supported by staff from the neonatal unit.
- A critical care outreach team was available seven days a week between the hours of 8am and 8pm to support staff with women who were at risk of deteriorating. Staff told us there were good communication channels between the outreach team and obstetric staff if there were any concerns around a women's deteriorating health.
- Venous thromboembolism (VTE) assessments were completed for all women during pregnancy and on admission to the hospital.
- There were arrangements to ensure that checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion in obstetric theatres of the Patient Safety First's Five Steps to Safer Surgery – an adaptation of the World Health Organization (WHO) surgical safety checklist.
- An audit of the WHO checklist for the period August 2015 to July 2016 (sample size 135 sets of records) showed that within obstetrics and gynaecology, the WHO checklist was present in 132 out of the 135 (98%) sets of notes. It demonstrated that 100% of these records had 'sign-in' documented 98% documented 'time-out' against a target of 100%.
- A multidisciplinary handover took place on labour ward twice a day, following a situation background, assessment, recommendation (SBAR) format. Staff from all areas attended this and discussed the sickest patients and areas of concern around the unit. Time was also used to teach less senior staff on a relevant condition or case, and how to anticipate concerns. This was not considered a formal safety huddle as anaesthetists were not involved. Staff told us anaesthetists would attend if indicated.
- During the initial booking appointment, pregnant women were given hand held maternity notes which supported antenatal care. Midwives took a full medical, obstetric, social and family history, which included an assessment of emotional well-being. This assessment was used to classify whether the woman was at low or high risk. Low risk women continued with midwifery-led care, whilst high risk women received consultant-led care. This assessment was repeated at 36 weeks gestation to enable discussions of intended place of birth, and again when being admitted to delivery suite, at a home birth or if there were any changes in pregnancy.
- A triage of care was in use in the antenatal day assessment unit. Pregnant women who called for advice received a telephone triage to establish the appropriate location of care. On arrival staff triaged women in order to see the most urgent cases first. Procedures were in place to ensure that women with reduced fetal movements received monitoring within 30 minutes of arrival.

Midwifery staffing

- The maternity department used the National BirthRate Plus acuity tool to calculate midwifery staffing levels, in line with guidance from the National institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015. Birth-rate plus is a tool used to calculate midwifery staffing levels, based on the ward acuity and needs of the women. Acuity is the measurement of the intensity of nursing care required by a woman. Data provided by the trust demonstrated that on average 18% of the time, there were periods when staffing levels did not meet acuity. Staff described and we saw the redeployment of staff to meet the service needs. Staff on labour ward felt that the staffing levels were appropriate to the needs of the service. In the event of high acuity an escalation process was in place. Staff from the community would support their colleagues for a period of time (not exceeding four hours). Between May 2016 and September 2016 community midwives were used to support labour ward on 26 occasions, totalling 116 hours.
- The serviced utilised the NICE 'red flag' system that alerted when patient safety was compromised due to staffing issues for example delay in suturing or not achieving 1:1 care in labour. Staff were happy to help out in other areas if the necessary. We did not see evidence of this during our visit.
- The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Midwives 2007), based on the expected national birth rate, was one whole time equivalent (WTE) midwife to 28 births. Pilgrim Hospital maternity midwife to birth ratio was currently 1:28, which was the same as recommendations.

- As of June 2016, Pilgrim Hospital reported a vacancy rate of 10.5% for maternity wards, zero for antenatal clinic, and 3.7% for community. This was based on 7.5 whole time equivalent vacancies. Funding was being redistributed to employ a new trust wide infant feeding co-coordinators post.
- At Pilgrim Hospital the Maternity and Gynaecology wards had an average sickness of 4.4% the number of FTE days lost was 949.57. This was slightly better than the trust average of 4.7%.
- Funded versus actual staffing levels were very similar with few vacancies. New preceptorship midwives were starting in October 2016. Sickness and maternity leave had however left gaps in staffing that were filled by staff doing extra shifts. The pool of bank staff was small and no agency staff were used. During March-June 2016, actual staffing figures for rotational midwives was 15 WTE staff less than the planned figures over the four months. For the same period antenatal clinic was 4.5 WTE staff (23%) below their planned figures and community 12.7 (17.5%) below.
- From April 2015 to March 2016, Pilgrim Hospital reported a bank and agency usage rate of 7.5% in the Maternity and Gynaecology wards. This was better than the trust average at 11.17% bank and agency staff. Staff doing extra shifts mostly filled vacant shifts. A bank staff closed social mediagroup had been developed to advertise vacant shifts. Staff told us this had helped with the planning of shifts. A bank induction process was in place. Bank staff received a monthly flyer reminding them to organise mandatory training and additional training such as commode cleaning video links. We were told that ward sisters worked clinical in times of sickness to cover vacant shifts. Following our inspection we were told by the trust that agency staff were not used in midwifery
- Electronic staff rostering was in use, staff were still able to request shifts and found that the current system used work well for their and the hospital's needs.
- Between April 15 and March 16 the turnover rate for the hospital based midwifery staff was 2.3%, this was based on 1.4 WTE leavers.
- Staffing levels were displayed in all the clinical areas we visited and we saw information displayed indicated actual staffing levels mostly met planned staffing levels. During our visit planned staffing figures met the actual staffing.
- Labour ward shifts were predominantly led by a band seven midwife. They would not look after a labouring woman in order to maintain an awareness of the demands of the unit.
- Between July 2015 and June 2016, 44 incidents were reported involving staffing. These were all due to the lack of suitably trained staff and all classed as no harm incidents. Many of these incidents highlighted that the escalation process had been commenced in accordance with unit policy. All incidents demonstrated a degree of investigation and assessment of escalation.

Nursing Staff

- Ward M1 incorporated the gynaecology assessment ward and early pregnancy assessment unit and were staffed together. The colposcopy and hysteroscopy unit had separate nurse specialists employed during clinic times. There were 2.2 nursing vacancies. Sickness and maternity leave was a significant problem on ward M2 and staffing featured on the risk register.
- During our inspection over three days, eight members of staff were off work due to sickness, which increased to 13 members of staff on the unannounced inspection. Managers told us all sickness was reviewed and no common themes existed. Bank and agency staff predominantly filled vacancies. The agency staff told us they had been orientated to the ward, or worked there before. They did not complete paperwork to confirm orientation and induction. So we were not assured that induction procedures took place, and staff were familiar with emergency procedures and accessing policies. Currently most shifts included using at least one agency nurse. Processes were in place if no substantive staff were on a shift to prevent staffing to be completely agency staff. Data received from the trust demonstrated a bank and agency use of 26% for March 2016.
- Nurses in charge of the shift on the maternity and gynaecology wards took a caseload of women, due to staffing numbers this was not a reduced work load.This meant that they still had to manage the ward and attend multidisciplinary handovers in addition to caring for women. Staff worked hard and co-ordinated work so we did not see delays in care due to this.
- Supernumerary periods for new staff were tailored to staff needs. The staffing problems were further impacted by the ward activity. During the inspection non-gynaecology women made up 68% of the women

and 50% on the unannounced inspection. This meant the staffing levels calculated appropriate for gynaecology patients was not always appropriate for the medical, surgical and orthopaedic inpatients.

- Data provided by the trust demonstrated, between April 2015 and March 2016, at Pilgrim Hospital the average turnover rate was 71% in the Maternity and Gynaecology wards, the rate is based on 16 whole time equivalents leaving.
- During the unannounced inspection there were 13 members of staff off sick that week. Despite this an extra outpatient clinic was in progress on the ward. Miscommunication between medical staff and managers had meant that no extra staff were supplied to support the running of the extra clinic. Support workers from the ward were assisting in the clinic. Staff told us this was not a regular occurrence and was very unusual but did increase the work load for the period of the clinic.
- Staff told us bed managers did not close beds on ward M2 if they were short staffed.

Medical staffing

- Obstetric consultant cover was 56 hours a week shared between seven consultants. Royal College of Obstetricians and Gynaecologists (RCOG) 2007 guidelines states that for a unit with less than 2500 deliveries a year then the unit must continually review staffing to ensure adequate cover based on local needs. Staff told us that staffing was reviewed regularly and a new consultant had been appointed to support colleagues. The trust did not currently have plans to increase consultant hours on labour ward.
- Recent changes had increased the continuity of consultant presence on labour ward by consultants working a 'hot week'. This meant the same consultant was present 9am to 5.30pm Monday to Friday. Staff explained that the reduced frequency of changing consultant ensured better continuity for women.
- Ward M2 consultant gynaecologist cover was 8.00am to 6.00pm Monday to Friday, with shared obstetric cover at weekends.
- Overnight consultants worked a non-resident on-call system allowing them to be up to 30 minutes from the hospital if required. If this was not possible a resident on call system was used.
- As of June 16 the vacancy rate for medical staff was 12.5% based on 3 vacancies out of 24 WTE.
- In Pilgrim Hospital the medical staff reported an average of 3.5% sickness rate, the number of WTE days lost was 294.
- Dedicated anaesthetic cover was provided twenty four hours a day with an on call anaesthetist available to cover for women who needed to go to theatre.
- From April 2015 and March 2016 Pilgrim Hospital reported a bank and locum usage rate of 7.5% in the Maternity and Gynaecology wards. Gaps in the obstetric trainee posts from the local deanery were responsible for the increased locum use.
- Junior staff described good support although shifts were often busy. A previous deanery visit had highlighted gaps in training experience for trainee staff. Consultants assured us this had been addressed and would not be an issue at the revisit later this year.
- Weekends and out of hours senior house officers provided cover for wards M1,M2, early pregnancy assessment unit (EPAU) and emergency gynaecology unit. Staff told us patient reviews were often delayed due to this. Staff working throughout maternity reviewed women in the antenatal assessment centre.

Major incident awareness and training

- The trust had a major incident plan, although staff understanding within maternity and gynaecology was limited. They were aware their greatest responsibility would be to make beds available if necessary. Staff said they would liaise with Lincoln County Hospital for transfer or diversion of women.
- All staff felt supported by site managers in the event of loss of power, water or IT.
- Modified practical obstetrics multi-professional skills drills training were developed for the maternity services. This is an accepted format by which healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies, for example haemorrhage, maternal collapse, and resuscitation of the newborn.

Are maternity and gynaecology services effective?

Requires improvement

We rated effective as requires improvement because:

Maternity and gynaecology

- The service used a maternity dashboard as recommended by RCOG (2008) but they did not use this to set local goals for each of the parameters monitored, as well as upper and lower thresholds
- Multidisciplinary maternity emergency skills drills were completed annually by all midwives. Midwifery compliance at these sessions was 93%, but in July 2016, 43% of medical staff had attended. This did not comply with National Maternity Review (2016) recommendations.
- The service held both cardiotocograph (CTG) training and meetings to review and discuss CTG's. Although 94% of midwives had completed CTG training, only 21% were able to attend the meetings due to difficulties leaving the ward during a shift.
- The fetal monitoring guidelines did not have an addendum highlighting the delay in following current NICE guidelines.
- Monitoring of patient outcomes statistics on the maternity dashboard, such as the percentage of women who had severe tears, was not taken into account to improve practice. This also meant that staff could not assess the data against trust targets.
- Many of the audits did not provide plans for presentation of findings to colleagues or current timelines.
- The trust had not fully implemented the Saving Babies Lives Care Bundle (2016).
- Delays occurred in receiving patient records during inpatient stays on ward M2.

However, we also found:

- Women's care and treatment was planned and delivered in line with current evidence-based guidance.
- Regular audits of practice were performed to review services such as fetal monitoring, post partum haemorrhage and epidural provision.
- Consent for disposal of fetal remains was gained in line with national guidance.
- On discharge from hospital women were given clear information documented in post-natal booklets.
- Normal birth rates were same as the England average. Emergency caesarean section cases were reviewed by medical and midwifery staff.
- The trust employed a practice development nurse and midwife to support staff training.
- Gynaecology-oncology services held a weekly trust wide multidisciplinary meeting.

Evidence-based care and treatment

- 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.
- Trust wide policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. Within gynaecology, the care of women requesting induced abortion (RCOG) and the Department of Health, Termination of pregnancy for fetal abnormality guidance was also followed.
- We reviewed 11 clinical guidelines; these were all easily accessible, in date and version controlled. Apart from the electronic fetal heart monitoring guideline, all guidelines we reviewed, referenced current up to date guidance from NICE, RCOG or equivalent.
- A trust wide maternity policy and guideline group had been set up. They were responsible for meeting bi-monthly to review and ratify maternity guidelines.
- Across the whole of United Lincolnshire Hospitals Trust, we saw minutes that highlighted discussion around guidelines and those planned for review at the next meeting.
- 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.
- The gynaecology unit followed appropriate guidance for the disposal of fetal remains. Patient consent for preferred method of disposal was gained prior to the start of a termination of pregnancy in accordance with RCOG guidance.
- Whilst the trust policy for disposal of fetal remains was in line with Human Tissue Authority guidance (2015), staff were not always following the policy in relation to the storage and disposal of fetal remains. If the paperwork was not completed accurately the products of conception or fetal remains would be returned to the ward. The nurse would have to recall the records to complete the paperwork. On the day of our

unannounced visit two containers had been returned that day. Staff told us the paperwork would be dealt with within 24 hours and returned to the laboratory. Staff told us that training for consent and paperwork completion was a current focus with shared learning from Lincoln County Hospital.

- The trust did not have clinical guidance in use for women receiving outpatient hysteroscopy (a procedure used to examine the inside of the uterus). This meant that we could not confirm that RCOG Best Practice in Outpatient Hysteroscopy was being followed. Medical staff assured us that this was the case.
- There was evidence to support NICE Quality Standard 37 guidance was being met. This outlines the expected standard a woman and her family may expect to receive during the postnatal period. For example, we observed that women were advised, within 24hours of the birth, of the symptoms and signs of conditions that may increase the risk of harm and require them to access emergency treatment. These details were included in the postnatal booklet.
- Women with risk factors for gestational diabetes were identified and offered glucose tolerance testing in line with the current NICE guidelines.
- We reviewed six fetal heart rate monitoring records. In all records, staff had made an hourly documented systematic assessment of mother and baby in accordance with national guidelines. In one recording, staff had not recorded a reason for discontinuation of the fetal heart monitoring, or timed and dated the end of the trace in line with guidelines. This meant staff could not confirm if the discontinuation was intentional. Weekly CTG review meetings occurred to discuss interesting or challenging traces.
- The anaesthetic team also audited the frequency of accidental dural puncture and post dural puncture headache rates. The audit highlighted that the feedback paperwork was not adequate and that getting feedback from women was challenging. Plans were in place to send women contact details if problems occurred in order to capture all women who suffered complications post epidural or spinal anaesthesia.
- An audit programme was in place for a range of service wide audits. Many of the audits did not possess timelines including a study of results and presentation of finding dates, despite 33% being ongoing audits. This meant staff were unfamiliar with the outcomes of the audits. We were told a greater structure would be added by the guideline and audit midwife.
- Data provided by the trust demonstrated changes to practice to monitor post partum haemorrhage (PPH, severe bleeding after delivery) more closely. This was an action from the ongoing PPH audit.

Pain relief

- Detailed information regarding available pain relief options available was provided to women in the antenatal period.
- Documentation we reviewed demonstrated a continuous assessment of women's pain relief options in labour.
- Labour ward had a birthing pool for the women to use as pain relief in labour.
- Entonox (a pain relieving gas) was available in cylinders for women in labour. Staff told us there was not a problem with ordering replacement cylinders if necessary. Pethidine and diamorphine injections were available if women required stronger pain relief.
- Within labour ward, epidurals were available for women in labour 24 hours a day, seven days a week.
- Women were able to access pain relief during birth and post operatively in a timely way. Analgesia was offered regularly, and the women we spoke to felt their pain was managed well. In ward M2 women told us they were offered pain relief regularly and were not left in pain.

Nutrition and hydration

- Fluid balance charts were completed and legible.
- Women were encouraged to make an informed choice on the best method to feed their baby. The service was awarded UNICEF level two Baby Friendly Initiative. The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding.
- Between September 2015 and June 2016, the service's breastfeeding initiation rates were 69%, and 60% on discharge from hospital. This was similar to national average rates of 74% and 60%. Data was not currently collected on the percentage of women breastfeeding on discharge from maternity care.

- The trust did not currently have an infant feeding co-ordinator. Staff all received training on supporting women with breast feeding. However, there was not a nominated member of staff for coordinating training and monitoring staff competencies.
- The Malnutrition Universal Screening Tool (MUST) was used to screen women for their risk of malnutrition throughout gynaecology. Fluid balance charts were used appropriately to record fluid intake and urine output.
- A choice of meals was available and women completed menu choices for the day.
- Women told us the meals were served on time and were acceptable.
- Women had a private room available for expressing breast milk in if required. This included suitable sterilisation equipment. Expressed breast milk was labelled and stored safely in accordance with trust guidelines.

Patient outcomes

- United Lincolnshire Hospital Trust (ULHT) used a maternity dashboard as recommended by 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) rating on it. This meant staff could not assess the data against trust targets. There would 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. Information provided by the trust included four months of data.
- Staff at Pilgrim told us the lack of electronic system made data collection long and slow via the delivery journal. An electronic record system was in development.
- 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%.
- Managers told us all cases of emergency caesarean section were reviewed by medical and midwifery staff.
- Between April 2016 and June 2016, the trustwide forceps and ventouse rate was 19% which was higher than the trust target of 10-15%.
- The induction of labour figure across the trust was similar to the trust target of 30% of pregnancies. Senior staff at the hospital told us that they didn't routinely monitor their induction rates.
- The dashboard was displayed in staffing areas but was extremely small and trust wide, reducing the effectiveness. It also featured on the agenda for the obstetrics and gynaecology governance meeting. We could not establish if the effectiveness of care and treatment was routinely discussed.
- An audit and policy lead midwife had been employed to give focus to the audits performed. The plan was once she had reviewed the audits there would be an improvement in the use of the evidence created.
- We saw trust wide data submitted to national data collection, such as stillbirth rates and National Obstetric Anaesthetic Database.
- Audit of data collected between July 2015 and November 2015 demonstrated that 88% of labouring women received an epidural within 30 minutes of their request. This highlighted a need for closer communication between anaesthetists and midwives. A re-audit was planned the following year. The anaesthetic team also audited the frequency of accidental dural puncture and post dural puncture headache rates. The audit highlighted that the feedback paperwork was not adequate and that getting feedback from women was challenging. Plans were in place to send women contact details if problems occurred in order to capture all women who suffered complications post epidural or spinal anaesthesia.
- For the period January 2015 and December 2015 the hospital stillbirth rate was 3.4 per 1000 births. This is less than the national average of 4.7 per 1000 births. The

trust benchmarked their rate and practice against other trusts and national guidance to ensure practice was up to date. All still births were reviewed by appropriate staff and presented at governance meetings.

- The trust had not fullyimplemented the Saving Babies Lives Care Bundle (2016). These are guidelines introduced to try to reduce the high stillbirth rate in the United Kingdom. They had identified the need and planned a phased approach.
- In the 2016 National Neonatal Audit Programme (NNAP), Pilgrim Hospital was same as or better than the NNAP standard for four of the five indicators. The trust did not meet the NNAP audit question "Are all mothers who deliver babies between 24 and 34 weeks gestation inclusive given any dose of antenatal steroids?" The trust gave 79% of the mothers steroids, just worse than the NNAP standard of 84%.
- Data provided by the trust demonstrated that between April 2014 and March 2015 544 full term babies were admitted to the neonatal intensive care unit. This figure was 56% of their unexpected admissions to NICU (962 babies).
- Trust wide national antenatal key performance indicators (KPI) were reported electronically for screening in pregnancy data. The antenatal KPIs not achieved in 2015, were the referral to gastroenterology services for hepatitis B positive women within 6 weeks of receipt of the positive result. The second was the completion of request forms for Down's Syndrome tests. Action plans were in place to address these areas.
- For newborn KPIs, the trust also achieved four out of six indicators. A report highlighted a significant improvement in the two KPIs not achieved. Only 2% of babies had received a repeated newborn bloodspot screening test, compared to 4% previously. Work was still ongoing to provide support and training for staff who persistently needed their tests repeating.

Competent staff

- One whole time equivalent (WTE) practice development midwife worked across both sites. Each site also had clinical educators to offer support. At Pilgrim Hospital the clinical educator post had been vacant for some time due to an inability to recruit. This had impacted on the delivery of training, for example live skills and drills.
- New starters were given an induction period incorporating mandatory training. This was initially for a month but adjusted to suit individual staff needs. A preceptorship package was available for the newly registered midwives that were due to begin in October 2016. We were told that study days would also be provided for the new starters.
- A band six development programme was planned to support staff working towards their band seven position. Staff told us work constraints restricted the opportunities to attend governance meetings and development opportunities. There had been increased demands on staff due to sickness and maternity leave.
- Several midwives had undertaken the Newborn and Infant Physical Examination course so they could discharge low risk babies following birth. The framework within which they practised was clear including a detailed list of neonates (babies up to 28 days old) they could review and those who needed referring to a neonatologist.
- A new matron for gynaecology across the trust was planning to implement more leadership opportunities, and increase training modules for the nursing staff. This included rewriting job descriptions for the specialist nurse posts and developing suitable staff for seconded management roles.
- Midwifery staff at Pilgrim Hospital received a modified practical obstetrics, multi-professional skills drills training. Due to the lack of medical facilitators, midwives delivered scenarios that were discussed This is an accepted format by which healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies, for example haemorrhage, maternal collapse, and resuscitation of the newborn. Obstetric anaesthetic staff supported the multidisciplinary training.
- Staff received updates in caring for women whose condition was deteriorating and had anaesthetic recovery training and competency assessment. This complied with the recommendations by the British Anaesthetic and Recovery Nurses Association (2012) to recover women following anaesthesia. However, data received from the trust demonstrated that in July 2016,18 midwives at this site were recorded to have undergone the training. Staff told us they spent a single day in recovery for training. The recovery policy did state that a three yearly update must be performed. The midwifery clinical educator told us that recovery training

was included in the preceptorship package for newly qualified midwives. The hospital had practice clinical educator posts working in both maternity and gynaecology.

- There were 21 supervisors of midwives (SoMs) across ULHT. This equated to a supervisor to midwife ratio of 1:14.9 in line with the national recommendation of 1:15. SoMs help midwives provide safe care and were accountable to the local supervising authority midwifery officer (LSAMO). All midwives had a named supervisor of midwives (SoM). Staff said they had access to and support from a midwifery supervisor. They reported the process was very similar to the annual performance review.
- The local supervising authority (LSA) had audited the SoM service and had produced a report with a number of recommendations for improvements. The SoMs had an action plan to raise awareness of the role of the supervisors and were performing a greater number of supervisory decision trees (a review of clinical incidents). The SoMs told us they had a process in place for allocation of investigations, although staff said they could be slow to complete.
- Data for the women and children's business unit demonstrated that in July 2016 81% of staff at Pilgrim Hospital had received an appraisal this year. All ward areas we visited had boards in offices with appraisal rates and dates due highlighted. The appraisal and training rates were on the agenda for the ward sister confirm and challenge meetings with the Head of Midwifery and Nursing. For September 2016 the appraisal rate for maternity was 94% and gynaecology was 93%. All staff we spoke to had received an appraisal in the last year.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They said they had good ward-based teaching, were supported by the ward team and could approach their seniors if they had concerns.
- Multidisciplinary maternity emergency skills drills were completed annually by all midwives. Midwifery compliance at these sessions was 93%, but in July 2016, 43% of medical staff had attended. This did not comply with National Maternity Review (2016) recommendations.
- Training included cardiotocograph (CTG) training and meetings. A greater proportion of medical staff than midwives attended the meetings, with 50% of medics attending and 21% of midwives. However, 94% of midwives had completed the CTG training sessions. Staff told us this was due to difficulty in leaving the ward during a shift.
- Not all staff supporting women undergoing termination of pregnancy had approved counselling qualifications which was not in line with RCOG guidance. They had received training in performing assessment of consent for the procedure.
- RCOG Safer childbirth minimum standards recommends that all midwives are trained and regularly assessed as competent in neonatal basic life support. Data for July 2016 demonstrated that 92% of staff had completed their training. This was similar to the trust target of 95%.
- Healthcare support workers were trained to work alongside members of staff supporting each other in performing and documenting women's observations. Each ward kept a record of the staff competencies. Staff in ward areas were nominated to monitor staff training.

Multidisciplinary working

- Staff reported that the multidisciplinary team (MDT) working within the department was efficient and effective. We saw minutes of weekly meetings that reinforced this.
- The physiotherapists and occupational therapists supported women after surgery on the gynaecology ward and for assessments prior to discharge home.
- Gynaecology-oncology services held a weekly multidisciplinary meeting. This was held using conference facilities to cover the whole trust and neighbouring trusts involved in patient's care.
- Advanced nurse practitioners worked closely with medical staff to provide an outpatient hysteroscopy service (a procedure used to examine the inside of the uterus).
- Women with complex pregnancies were referred to neighbouring hospitals where there were facilities to support those who were at higher risk in pregnancy.
- Multidisciplinary clinics were held for women with more complex needs, such as haematology clinics and clinics for women with diabetes.
- Anaesthetic staff saw women deemed high risk for anaesthesia in the antenatal period.
- Staff told us the implementation of consultant 'hot weeks' on labour ward had improved MDT working. The same consultant obstetrician was present 9am to 5.30pm Monday to Friday.

- Electronic summaries of care were sent from hospital to health visitors and GPs. Following a termination of pregnancy women were given a detailed discharge letter and prescription for contraception, or advice and signposting if she was undecided on her chosen method of contraception.
- Community midwives reported that having a base within the hospital meant they could find medical staff for support when necessary.
- Babies requiring additional care such as observations or antibiotics were cared for in one of the transitional care cots within postnatal ward M1. Midwives and nursery nurses worked together to provide a holistic approach to care for mothers and babies.
- The new antenatal and postnatal ward due to open in December would provide rooms for inpatient and community midwifery managers to be available in the clinical areas. Training and meeting rooms for all staff would also be available on the ward.

Seven-day services

- The Early Pregnancy Assessment Unit (EPAU) provided early scans and consultations for women experiencing problems in pregnancy between 6 and 18 weeks gestation. This was based on ward M2 and was open Monday to Friday 7.30 am to 4pm. There were five scans available each day for staff to refer women with bleeding or concerns in early pregnancy. Out of these working hours women would attend emergency departments, or leave a message in a non-urgent situation, for example a very small amount of vaginal bleeding.
- Community midwives were available 24 hours a day, seven days a week to facilitate home births.
- GPs could refer women directly to the gynaecology ward 24 hours a day by contacting the on call gynaecology doctor.
- The maternity assessment day unit was open 8am to 4.30pm Monday to Friday. Staff told us women requiring review had to wait due to medical staff working elsewhere in the hospital. There was no doctor rostered to work in the department due to the fact that not all women seen required medical review. Outside these hours women attended labour ward or M1 for assessment.
- A supervisor of midwives (SoM) was available 24 hours a day, seven days a week through an on-call rota. Women and staff called the labour ward to access the SoM on duty. This on-call system provided support to midwives and women at all times. The hand held antenatal records included details of how to contact the on-call SoM. The LSA audit did question if this was the best way to contact the on call SoM as there was a risk of labour ward midwives acting as a 'gatekeeper' to calling the SoM. The trust investigated the possibility of the switchboard being responsible for the on-call rota, but this was not possible due to financial constraints.
- Consultant obstetricians, gynaecologists and anaesthetists were either resident on the unit or on-call 24 hours a day, seven days a week.

Access to information

- Medical records were accessible and available for both gynaecology and maternity clinics. Staff said that due to the geographical nature of the county that sometimes women attended the hospital when their main notes were still across the county at an outpatient clinic. Due to women carrying their own notes this did not impact their care. All pregnant women carried their own handheld records which included risk assessments, ultrasound and blood test results, to ensure continuity of care and accessibility of information. Within gynaecology wards notes for inwomen were not always available. We saw records on ward M2 waiting for the main notes to arrive to combine the records. This meant if the patient was admitted again prior to this happening the latest information would not be available. The risk to patient care was highlighted on the risk register.
- Staff were able to access test results via the trust's IT system.
- Business plans were written and funding approved for a paperless electronic system. Staff worked to ensure the current electronic record systems would be compatible. A midwife had been seconded to lead the project.
- There were white boards on the walls of inpatient areas, which included women's surnames. However, no other identifiable information was recorded on the whiteboards. Staff used codes and initials in an attempt to maintain confidentiality.
- Staff within the gynaecology-oncology service were informed of women's admission to the hospital no matter why they were admitted. This was to support the sharing of information and to support the woman.
- GPs and health visitors were informed of women's discharges from hospital via electronic transfer of information.

Maternity and gynaecology

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards policy, however, this had no date of approval or date of review on it. The trust also had a consent for examination and treatment policy. This was in date with a review date.
- Training on consent, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards and learning disability was part of mandatory training for all staff. This had been completed by 95% of staff within women's and children's services so met the trust target of 95% completion.
- Consent to care was obtained in line with national legislation and guidance, including the MCA.
- Staff were aware of their roles within the mental capacity act and how to cater for women's individual needs.
- Within the termination of pregnancy clinic, as part of the care pathway women were given sufficient time to ask questions and to spend time with a member of staff prior to giving consent to the procedure. During this time all options were sensitively discussed with the woman and where appropriate their partner. Women were offered a second consultation if they were not entirely certain about their decision to terminate their pregnancy.
- The trust's consent for examination and treatment policy supported making the patient's best interests central to the process of obtaining consent. If a young person was under 16 and wished to consent to their own treatment, for example if they wished to undergo a termination of pregnancy, staff followed Gillick Competency and Frazer guidelines to assess whether the young person would have the maturity and intelligence to understand the risks and nature of treatments. Gillick competency and Fraser guidelines are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions. The young person would be given time to consider all the options.
- Secretarial staff monitored documentation completion rates and avoided delay in women's treatments.
- Staff members within the termination of pregnancy clinic were aware of the complications that could arise from using family members to interpret for women who did not speak English and were considering a termination of pregnancy. Where possible women were seen on alone with an interpreter.
- Women gave consent for their care and treatment, and this was clearly documented in their records. We observed staff asking for consent prior to undertaking care and treatment such as blood tests and physiological observations.
- Within the gynaecology outpatient service registered nurses received training on the application of informed consent. We saw that staff discussed risks and complications and gave women the opportunity to ask questions before they asked the patient to sign their consent.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- We observed women and families treated with kindness and compassion.
- Women were treated with dignity and respect, and partners felt included in the care.
- Feedback from women using the service reflected kind compassionate care
- The trust performed better than other trusts in the CQC maternity survey 2015.
- We saw staff spending more time with those of greater need.
- Staff within maternity and gynaecology had great understanding of the support required by those experiencing loss.
- Staff self-funded bonding blankets to support women during difficult times.

However, we also found:

- The unit struggled to gain feedback from non-English speaking families.
- There were no designated rooms on M1 or labour ward for families who had suffered a bereavement.

Compassionate care

- We observed ward areas, listened to focus groups and spoke with individual staff who were involved in patient care. Throughout the service we saw sensitive interactions and found that staff responded compassionately, treating people with kindness, dignity and respect.
- Women told us that staff were respectful of privacy and found private places to speak if appropriate. We observed staff respecting the privacy and dignity of women by knocking on doors and waiting to be invited in to the room, or behind the curtains around the woman's bed space.
- Staff were sensitive to the personal, cultural, social and religious needs of the individual women.
- Between July 2015 and June 2016 the trust's Maternity Friends and Family Test performance (% recommended) was generally similar to the England average in the four areas of maternity, which are antenatal care, postnatal ward, birth and postnatal community. Of the responses for the postnatal ward and community, 97% of women would recommend the care to friends and family. In August 2016 the trust wide service received 11 responses from women in labour. The service felt that women responded on their hospital experience as a whole. Prompt cards were given out as women left hospital to encourage feedback. The postnatal community service received 120 responses.
- Feedback was not always gained from the non English speaking members of the public.
- The trust performed better than other trusts for two out of 16 questions in the CQC Maternity survey 2015, in all other areas it performed about the same. The two areas which were better than other trusts were: being given appropriate advice and support when the patient contacted a midwife of the hospital, and whether the patient felt the length of stay was appropriate.
- Staff performed handover in side rooms to maintain women's confidentiality.

Understanding and involvement of women and those close to them

- A national champion in healthcare report highlighted that women felt they received individualised care. They said they felt assured that staff were around when they needed them. They reported that at timed they found it difficult to understand the medical jargon of the doctors, but a midwife chaperone was available to answer questions.
- Midwives took time to explain procedures and women felt involved in their care.
- A partner we spoke with felt included in care particularly because they were given the option to stay in the hospital to be with their family overnight.
- Prior to discharge home staff discussed with women the signs and symptoms that they should look for and when and how to seek advice. Interpreters were used for this to ensure women and families understood. We saw staff using language line to discuss discharge arrangements with a family for whom English was not their first language.
- Women considering a termination of pregnancy were given time to consider their decision. Staff were sensitive to enquiring on the reason for termination and careful to consider the women's privacy.
- Women told us that appointments weren't rushed and their midwives gave them information in understandable language.
- We observed care of a woman suffering a recent bereavement. Staff started to make plans and nominated an out of the way delivery room for use on admission.
- Women considering a termination of pregnancy were given time to consider their decision. Staff were sensitive to enquiring on the reason for termination and careful to consider the women's privacy.
- Families were offered support towards the cost of parking. This was phrased in a dignified way for families to approach members of staff to discuss their concerns further.

Emotional support

- Women we spoke with told us they were asked in pregnancy about their emotional and psychological wellbeing. This was reflected in the notes we looked at.
- Staff described how they took time to give emotional support to women who had experienced a miscarriage, termination for fetal abnormality, still birth or a neonatal death. Birthing partners were encouraged to stay with women on the postnatal ward to provide extra support and promote the family unit.
- Staff worked hard to support women who had experienced a miscarriage, termination for fetal abnormality, still birth or a neonatal death. They told us that this could be a rewarding if sad aspect of their role.Staff self-funded and chose to create items to

support the emotional trauma of losing babies or having a sick baby. They asked a local charity to tailor memory boxes to meet the hospital diverse culture. 'Bonding blankets' were made for women whose babies were cared for on the neonatal unit. Families were supplied with two small blankets, one for parent and one for baby to exchange scent of parent and child.
- The hospital chaplain provided appropriate emotional support to women and those important to them.

Are maternity and gynaecology services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There was no designated midwife led unit, giving women the choice of a home from home environment.
- Due to medical staff commitment, women attending for emergency gynaecology appointments waited for unpredictable lengths of time. The length of wait was not audited.
- There was not a suitably quiet or secluded room, designated for a woman to deliver a still born baby, or spend time with a partner and baby.
- Due to limited bed space for gynaecology women admitted for termination of pregnancy were cared for alongside women with a wide variety of conditions.
- The trust did not have specialist midwives to support vulnerable women, for example, teenage pregnancy, substance misuse, domestic abuse or the migrant population.
- Women using the recovery area post emergency procedures would be cared for in a small area that opened directly onto the theatre corridor. This was not used consistently.

However, we also found;

- The service had increased the number of trust wide specialist midwives. Some of these such as the bereavement midwife had not started.
- The trust had reintroduced birth preparation classes. A digital virtual tour would also be available.
- Staff were aware of their roles within the mental capacity act and how to cater for women's individual needs.
- Women and families knew how to raise a concern and were treated compassionately when they did.
- Women undergoing an elective caesarean section received continuity of carer. She was cared for by the same midwife throughout admission, operation and on return to the ward.
- Elective caesarean sections were performed in main theatres preventing a delay in operations.

Service planning and delivery to meet the needs of local people

- The trust had recently employed specialist midwives to provide extra support to women and families with more complex needs. The posts were new and some staff were not in position. This included a bereavement midwife, a midwife with specialist safeguarding knowledge and a weight management/diabetes midwife. The safeguarding lead was able to support the staff in caring for families with extra social needs. Across both sites, this was approximately 193 known child in need and child protection cases. At present there was no infant feeding co-ordinator, although that was due to be addressed. Local public services had cut the provision of smoking cessation support, although all midwives promoted stopping smoking.
- Women were given a choice of where they wished to give birth in line with national guidance, which recommended both a choice in place of birth and a lead carer. This included the choice of a home birth or birth in a hospital supported by midwives, consultant obstetricians and anaesthetists.
- The service did not provide a designated midwifery led unit, although women who were deemed to be at low risk did receive midwifery led one-to-one care in labour within the consultant ward. Staff attempted to make a more homely environment in two labour rooms although one was without an en-suite toilet. The remainder of the delivery rooms were very clinical with theatre type sinks and access doors using all available wall space. This meant that the delivery bed remained in the centre of the room and the focus of the room. No signage in the rooms promoted normality, positivity or the principle to get 'off the bed'.
- Consultants and midwives ran combined clinics for women with endocrinology complications and weight

management clinics. These had been trialled in Spalding to reduce the distance women had to travel. Antenatal weight management clinics were run in conjunction with the diabetes clinics.
- Anaesthetists ran clinics for women who were deemed at higher risk during anaesthesia.
- Midwives ran anti D clinics within the clinic. Anti-D is a medicine used to prevent antibody formation in women who have a rhesus negative blood group and who have a rhesus positive baby. This can lead to complications that may affect the baby after birth, or complications with a different pregnancy at a later stage should the woman become pregnant again.
- Community midwives liaised with link staff for the Polish community at local children's centres. This was to increase the local awareness of maternity services and identify areas for improvement.
- A new modular build ward was nearing completion although an opening date had not been confirmed. This would provide spacious antenatal and postnatal beds for women with specialist hoists and en-suite facilities in all the single rooms. A large dining room would give women and families the opportunity to mix and spend time away from the bedside.
- Nurse led termination of pregnancy clinics and early pregnancy clinics were run on ward M2. The week of the inspection, staff had moved the early pregnancy clinic to the afternoon as a trial, to minimise the overlap with antenatal scan appointments in clinic. It was appreciated that this would be upsetting for women losing a pregnancy.
- Colposcopies and hysteroscopies (a procedure to find out if there are abnormal cells on or in a woman's vagina or cervix, and a procedure used to examine the inside of the uterus) took place in a room off the ward. There was a consulting room with a couch where the women were consulted and procedures were performed. Separate recovery areas and waiting room were provided for women undergoing day case colposcopies.
- Antenatal care was provided in GP surgeries, children's centres and at the maternity unit. The service offered specialist antenatal clinics including a multidisciplinary diabetic clinic and haematology clinics.
- The hospital had a dedicated screening co-ordinator, the service was supported by the antenatal clinic lead. Women requiring more invasive screening were referred to neighbouring tertiary clinics.
- Parent education classes had recently recommenced and were described as birth preparation classes. Staff reported that the uptake of these clinics were poor. A digital tour of the unit was in production in view of the high demand for women to tour the unit.
- Women who were admitted for terminations of pregnancy were admitted directly to the gynaecology ward, although were not always allocated a single room. Staff attempted to provide single rooms, but due to bed capacity there were times when women undergoing a pregnancy loss or termination of pregnancy could be nursed alongside other women with a wide variety of conditions.
- Women attending on the ward with emergency gynaecology symptoms would often have to wait for long periods

Access and flow

- Women requiring urgent gynaecology or early pregnancy care were seen on ward M1. Due to the unpredictability of the service women would sometimes have to wait for long periods, either due to the lack of available doctor, or due to waiting for an USS. There were no dedicated same day emergency USS appointments. The ward did not audit waiting times, but kept women informed at all times.
- The elective caesarean section (CS) theatre list ran two mornings a week. Routinely three cases a day were booked. The elective caesareans were performed in main theatres with support of nominated theatre and midwifery staff. This meant that women's operations were never delayed by emergency surgery.
- During the period April 2016 and May 2016 between 84% and 88% of women attended for antenatal services within 12 weeks of their pregnancy. This was close to the trust target of 90%.
- Trust wide, medical and surgical terminations were offered to women up to 12 weeks and six days. Women beyond that gestation were referred to an alternative independent termination service. Women attending for an appointment to discuss a termination of pregnancy were offered the procedure within five working days of the decision to proceed. Surgical terminations of pregnancy were not offered at Pilgrim Hospital. Women choosing this method attended Louth Hospital.
- Elective gynaecology surgery was carried out within the day case theatre.

- Between January 2016 and June 2016, on average 94% of women waiting for a gynaecology-oncology appointment were seen within two weeks, which equated to 966 women. This was better than the trust target of 93%.
- The trust did not collect data relating to the percentage of women seen by a midwife within 30 minutes and if necessary a consultant within 60 minutes during labour. However, staff told us it was unusual for women not to be seen immediately on transfer to labour ward. Ward staff told us if they thought there would be a delay on labour ward the midwife on ward M1 would review a woman there.
- Staff across the service used an electronic bed state to monitor bed vacancies and inductions of labour. Staff told us if work load was becoming unsafe then the system allowed staff to monitor if women could be diverted to the other hospital. This was performed prior to escalation to silver command. The gynaecology ward did not monitor the occasions when women from other specialities (outliers) were cared for on ward M1. This was a regular occurrence. During the inspection, 50-68% of the beds were occupied by non gynaecology women. Staff told us it was unusual for elective gyneacolgy surgery to be delayed due to the lack of beds, although patient flow was a challenge.

Meeting people's individual needs

- A named midwife was included in the women's handheld records for care during the antenatal and postnatal periods. We saw evidence of staff using language line and face-to-face interpreters throughout pregnancy, delivery and the postnatal period. Many leaflets throughout the unit were in Polish, Russian and Latvian, as these were commonly spoken languages.
- All women admitted over the age of 75 had a confusion score documented within the care plans. The confusion assessment highlighted those at increased risk whilst in a new environment.
- Staff used a quiet room in clinic for breaking bad news. This was in a corner of the clinic with a choice of exits.
- Women at higher risk who requested a water birth could not receive fetal heart rate monitoring due to the lack of telemetry monitoring.
- There was no dedicated bereavement room available for women and families suffering a bereavement. One of the delivery rooms at the end of the corridor was used due to the en-suite facility. This was however, between the staff desk and theatre recovery. If a woman decided or needed to go to the postnatal ward there was no dedicated room for her. Staff were sensitive that the needs of the individual woman should be considered.
- Staff on labour ward offered a midwife led experience within the consultant unit, this included the tranquillity room including a birthing pool and a room with a delivery beanbag. Staff tried to increase the visibility of these rooms to improve women's awareness. The lack of a midwife led unit, either stand alone or alongside within the area reduced the choices offered to women. The birthing numbers had dropped from the previous year. Although no formal analysis of these figures had occurred, staff felt the lack of MLU was a factor in women's decision on where to birth. The lack of telemetry fetal monitoring meant that women deemed of at higher risk were unable to labour in the birthing pool.
- Partners were invited to stay overnight on ward M1 if they wished. At present there were washing facilities, but no shower facilities for partners that did stay overnight.
- Not all labour rooms had en-suite toilets, which would mean a woman in labour would have to either use a commode in her labour room, or dress and move across the corridor to use the toilet. This could be undignified, uncomfortable or disruptive to the relaxation for women.
- Following a termination of pregnancy, women could access external counselling support.
- Staff spoke of the support offered to staff and women from the Mental Health Liaison Team. These were based at each hospital and contactable 8am to 10pm seven days a week. They reported that although the mental health liaison team had improved support, support for women with complex social or mental health needs was quite limited. There were no specialist midwifery teams to support vulnerable women during pregnancy. During acute crisis, the mental health team were supportive, but did not have capacity for longer-term support.
- The trust had not been able to fully implement recommendations from NHS England Saving babies lives report (2016). Due to the lack of local authority public health funding there was not a smoking cessation midwife. Also, the current limited availability of USS

appointments meant that current guidance of increased serial USS assessments or USS surveillance could not be followed. The trust told us they had plans to implement a staged approach to implementing the guidance.
- We saw an inconsistent approach to the plotting of the maternal symphysis-fundal height (measuring the growth of the womb) to detect babies that were not growing. We reviewed six sets of notes, three of these had the height measured but not plotted on the graph. This meant that there was the potential to miss a baby that has stopped growing.
- The trust only offered surgical termination of pregnancy at Louth Hospital. Staff felt this restricted patient choice. Data was not collected on those who changed their preferred method of pregnancy termination or went back to the GP to be referred to a local private clinic due to the distance and lack of transport.
- Women undergoing an elective caesarean section attended ward M1 and had the same midwife caring for her throughout admission, operation and on return to the ward. This meant that continuity of carer was maintained throughout the procedure. A second midwife was available during the procedure in the event of an emergency.
- The recovery area on labour ward was an open plan area with folding screen on the theatre corridor. This was not kept set up for theatre recovery and would not provide a quiet private space for the recovery of a woman post theatre procedure. The theatre corridor was due to become the thoroughfare for women to transfer from labour ward to the new maternity ward when it opened. This would mean that the folding screen would have to be closed across the recovery area causing the space to become cramped. Staff told us due to the nature of the room, and a patient complaint it was rarely used. This meant the space was not set up ready for use, but was still designated as the recovery area.
- Gynaecology staff on ward M2 predominantly cared for women with non gynaecology needs.
- Dementia and learning disability nurses were available for staff to contact for support with women with more complex needs. Staff we spoke with had not had much experience of looking after women with complex needs, but described liaising with the women and family and if necessary the safeguarding midwife. Staff were confident that they would have the time and facilities to meet a women's needs.
- Gynaecology nurses received training on dementia awareness as part of their mandatory training.

Learning from complaints and concerns

- Patient Advice and Liaison Service (PALS) information leaflets were displayed in clinical areas and information about contacting PALS was available on the trust's website.
- Between June 2015 and May 2016, 19 complaints were received for maternity and 45 gynaecology complaints. We were told changes to pregnancy loss leaflets was as a result of a patient complaint.
- The women we spoke with felt able to complain, but had not had reason to. They told us they would discuss their concern with the ward staff first.
- Matrons and the Head of Midwifery and Nursing addressed patient complaints. If it was felt necessary the Head of Midwifery and Nursing visited women to discuss their complaints. After complaining, women were offered the opportunity to receive a letter or meet face to face to discuss the complaint. A transcript was provided of any meetings.
- We were told staff in all areas would try to address women's concerns when they occurred, and signpost them in the right direction if appropriate.
- We saw minutes of meetings highlighting to staff that poor communication was the greatest cause for complaint. Staff were encouraged to reduce the amount of jargon used when discussing care as a result of complaints.

Are maternity and gynaecology services well-led?

Good

We rated well-led as good because:

- The women and children business unit strategy was driven by quality and safety. Short-term changes were performed to improve services for women within the current constraints.
- All levels of the governance framework functioned effectively, with exception of the current maternity dashboard and were embedded into every day practice. This included the changes that had occurred in the last two years.

- A strong business unit team had increased the visibility of the women and children business unit in the last 18 months.
- An increase in the number of matrons had strengthened the clinical supervision of staff and improved the leadership at local levels and trust wide.
- Teamwork throughout the hospital was apparent and something all staff were very proud of.
- Gynaecology outpatient services were increasing to reduce the physical and emotional disruption of treatment to women caused by inpatient treatment.
- Staff looked forward to moving to new ward areas.

However we also found:

- The uncertainty of the future model of maternity services was impacting on the estates and facilities provided
- Data collection was not as robust due to the lack of specific maternity IT systems, although changes were in place which should improve this.

Vision and strategy for this service

- United Lincolnshire Hospitals NHS Trust has been developing a five year strategy since 2014 which aimed to develop a portfolio of high quality services delivering excellent care.
- They were looking to develop new and innovative models of care, which will fully integrated partnership care pathways across primary and acute health. A multi agency approach was used to develop care systems to be delivered through a five-year place based Sustainability Transformation Plan (STP). At the time of our inspection there were no clear plans of how that service will look, or where women's and children's services would be provided.
- The current vision for the service had been overshadowed by the uncertainty of the future plans. Throughout the hospital the uncertainty of the service, was at the forefront of staff's minds. However, staff kept improving quality of care for women at the centre of everything they did.
- Women and children's business unit had developed strategic plans to improve the physical environment of the maternity block. These have included short-term cost effective alterations to improve conditions, and the provision of a large antenatal and postnatal ward. These will not provide the midwife led facilities required to improve compliance in keeping with the Maternity Review 2016.
- Staff within the trust were aware there were many changes in the future, but could not articulate what these may be. The move to the new wards for both maternity and gynaecology were a focus at present. They expressed that the women and children's service would possibly be united across both sites, but could not visualise the service.
- The women and children's business unit leads met regularly and played an active role in the development and monitoring of the sustainability and transformation plan.

Governance, risk management and quality measurement

- A well-defined governance and risk framework was in place and part of everyday practice. The maternity risk management strategy outlined the roles and responsibilities for all staff across maternity services. It gave clear guidance to support safe and effective care, and ensure that risk management in maternity services was consistent with trust risk management policies.
- In the past two years, the governance arrangements and structure had been strengthened significantly. This included monthly multidisciplinary maternity governance meetings and quarterly trust wide meetings. We were told by staff that there was an improved trust wide awareness of governance issues. 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.
- Weekly multidisciplinary unit incident meetings occurred (IR2 meetings) to discuss reported incidents. This included good practice and areas for improvement. The notes of this meeting were emailed to all staff to be aware of recommended actions and trends in incidents.
- The increased awareness of risk and incidents had made staff more aware of the incident review process. Some felt this could still feel punitive, but could not give examples why, however, they appreciated the fact that good practice was also recognised.
- Quality and performance data was monitored through trust wide governance meetings that fed into the business unit performance review. The maternity dashboard was currently under review, and data

provided by the trust did not include a red, amber, green flagging system. The lack of electronic maternity data management systems meant that data was collected manually, and not always consistent. The introduction of a maternity IT system was underway, and staff told us data collection would become more robust.

- The local risk register assisted the corporate governance group to identify and understand risks. There were 17 risks identified for maternity and gynaecology. Of the risks, nine were classified as extreme or high, six were identified as moderate risk, and two was classified as a low risk. We reviewed information which indicated the description of the risk and subsequent action taken, plus the outcome where known. For example, the lack of registered staff available to work on ward M2. Staff had authority to book bank and agency staff to fill the shifts that were short staffed. We found there was clear alignment of what staff had on their worry list with what was on the risk register.
- A systematic programme of clinical and internal audit had been developed, however, demonstration of completion and presentation dates was not always clear. Many audits were described as ongoing with little evidence of actions taken from them. The governance team recognised this, and seconded an audit midwife. Part of her role was to strengthen the process and improve feedback on the ongoing audits.
- HSA1 forms were completed by two doctors who followed national guidance and submitted the forms to the Department of Health as required.
- The assessment process for termination of pregnancy legally requires that two doctors agree that at least one and the same legal grounds for termination of pregnancy are met and sign a form to indicate their agreement (HSA1 Form). We looked at two termination of pregnancy records and found that both forms included two signatures and the reason for the termination.
- The government had commissioned an independent investigation into maternity and neonatal services at Morecambe Bay (the Kirkup report, 2015), to examine concerns raised by the occurrence of serious incidents. Good practice would be to benchmark against these recommendations. Data provided by the trust demonstrated the service monitored compliance with key elements of the Kirkup report, such as improving duty of candour and feeding back to families.

Leadership of service

- The women and children's business unit demonstrated a clear leadership structure which included strong clinical engagement. Consultant staff told us there was a proactive approach to decision making, such as the developing of the consultant 'hot week' role. The leads were aware their visual presence was not always apparent in all areas, particularly trust wide. This appeared to be mitigated by the employment of strong matrons who could represent the Head of Midwifery and Nursing (HOM) and have more time to communicate with staff. The planned employment of a deputy Head of Midwifery and Nursing would further support this. Despite this reduced visibility staff all felt that the leadership of the service was strong and driven, with women and children at the heart of everything the team did.
- Maternity and gynaecology consultants admitted there had been a degree of silo working within the two hospitals. Recently staff had developed cross-site working to ensure clinics were no longer cancelled due to staff shortages and holidays.
- The change in leadership style over the previous two years had been a challenge for ward leaders and staff. The 'confirm and challenge' session held monthly with the HOM caused a change in management style. Ward leaders at both hospitals told us they now felt confident in the management of their wards and were always aware of staffing, sickness, appraisals, training and budgets. Trust wide matrons told us the new proactive style had given them the confidence to move the service forward, and felt it was respected more by the trust as a whole.
- The relationship between the clinical director and the three members of the women's and children's senior team was described as open and very much a partnership. Senior consultants at the hospital felt that Pilgrim Hospital was not the main focus of the clinical directors plans. This was not supported by the clinical director. The services were the focus of the whole trust long term plans.
- The staff within the hospital felt that there was good teamwork and positive local leadership. Staff described the visibility of matrons and the Head of Midwifery and Nursing as mixed, but all new they could contact a manager if necessary. A new matron was in place to support trust wide gynaecology services. Staff expressed

this gave gynaecology greater direction and leadership. We saw evidence of the gynaecology matron coming to the hospital at short notice to support staff due to staff sickness.
- All midwives had a named Supervisor of Midwives and had received their annual review.
- We saw excellent local leadership in place on M2 ward from junior sisters. They attended multidisciplinary meetings and through the support and respect of colleagues carried the ward through a very difficult time of increased sickness, including the ward manager.
- Staff expressed that their ideas were considered and appreciated. They told us changes appeared a little slower to implement at Pilgrim Hospital, such as the use of core staff in ward areas.
- Staff within gynaecology felt that the profile of the service had been elevated in the last two years by the Head of Midwifery and Nursing. They appreciated the employment of a matron overseeing both sites.

Culture within the service

- We observed strong team working, with medical staff and midwives working cooperatively and with respect for each other's roles. All staff spoke positively and were proud of the quality of care they delivered, but felt that time to care was limited. In most areas, staff did not feel that the two hospitals worked together well and the services operated separately.
- Staff in both hospitals had worked hard during some difficult financial times. They felt that managers appreciated the hard work, but they did not always feel included in long-term changes. Staff were aware of ward meetings and described that minutes were shared locally, but didn't know of changes that occurred at Lincoln hospital.
- The culture within the service did encourage candour with an open and honest culture. This was demonstrated in the sharing of incidents and learning both via emails and the newsletter. Staff were also directed to the trust policy as well as external websites for further examples of duty of candour. We saw evidence of this in the review of debriefs with families after emergency procedures. A proforma for this was included in the intrapartum booklet.
- Junior doctors felt part of the wider team and well supported although they did describe being very busy.
- Labour ward staff described many occasions where the staff supported eachother around the hospital. This was often due to high acuity, but staff felt that the 'family feel' of the hospital promoted this.

Public engagement

- The HOM, midwifery matrons and community midwives attended the Lincolnshire Maternity Service Liaison Committee (MSLC) meetings on a quarterly basis. The MSLC is a forum for maternity service users, providers and commissioners of maternity services to come together to design services, that meet the needs of local women, parents and their families. We saw minutes of the June 2016 meeting that described discussions around the learning form incidents, friends and family tests, the workforce and recent publications. Unfortunately there was minimal user engagement within the group.
- The new ward boards included a 'you said, we did' area free text of changes, such as partners staying overnight and a speed up in the process for dispensing take home medicines.

Staff engagement

- Most staff told us they had confidence that they were informed of significant changes, although the delay in opening the new ward had caused upset. The wait for the outcome of the STP project appeared to overshadow all other short term plans. Staff told us the HOM had called emergency meetings due to the press announcing wrongly that Pilgrim maternity unit would close.
- We saw minutes from the new midwifery council meetings. These included documentation of changes suggested by staff such as the use of an elective caesarean section box for ensuring stock was available. Ward areas appeared to involve staff in decision making, such as the names for the low risk room on labour ward and who should open the new maternity ward.
- The unit managers had recently introduced a newsletter that was emailed to all staff and had copies in the staff lounges. This included a range of trust wide information on changes. Some staff were not aware of the newsletter although we saw it in coffee rooms.

Maternity and gynaecology

- Midwives with a specialist interest in normality in labour, planned and led free study days for staff across the trust. This included external speakers providing staff to learn from other units and use the information to drive change

Improvement and sustainability

- Women previously receiving endometrial ablation under general anaesthetic, (surgical removal of the lining of the womb) were receiving new outpatient treatment. Staff also provided outpatient uterine polyp removal (removal of small mass in the womb). Staff told us that this was preferred by women as was a one stop shop, and did not require an anaesthetic.

Services for children and young people

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

Information about the service

United Lincolnshire Hospitals NHS Trust provides care for children and young people at Lincoln County Hospital and Pilgrim Hospital Boston. Pilgrim Hospital paediatric service cares for children up to and including the age of 16. Children with complex needs are admitted up to the age of 19. The service includes an inpatient ward with 19 beds (Children's Ward) which is open 24 hours a day, seven days a week. There are also dedicated paediatric outpatient services provided at this hospital.

Pilgrim Hospital has a level one neonatal unit with eight cots providing level one care for new born infants requiring additional nursing care (special care). There are also four cots used for transitional care to children within this age group.

Between April 2015 and March 2016, there were 2,794 admissions to the children's and young people's services at this hospital. Of these 97% were emergency admissions, 1% planned admissions and 2% day case admissions. Between September 2015 and August 2016, there were 326 neonatal admissions. There were 24,708 paediatric outpatient episodes between November 2015 and October, the majority of these (66%) were conducted in outpatient areas not dedicated to paediatrics.

During our inspection, we visited the Children's Ward, the neonatal unit and the children's outpatient department. We also visited outpatient areas, which were not dedicated to children; however, children attended these areas for appointments. We spoke with 33 staff members, four patients and 16 family members or carers. Before our inspection, we reviewed performance information from, and about the trust.

Services for children and young people

Summary of findings

Overall, we rated this service as good because:

- Staff demonstrated a good knowledge about incident reporting and evidence of learning from incidents. The numbers of incidents were low compared to other sites within ULHT and there had been no never events or serious events in the last 12 months.
- There was evidence of good risk assessments for children and young people admitted to the service at this hospital, this included infection control; bed rails assessment and skin integrity assessments. There was evidence of reviewing the risk assessments within the appropriate timescales. Regular pain assessments were undertaken adapted to the age group of the child being assessed.
- There were no reported cases of MRSA bacteraemia or Clostridium difficile for the service in the last 12 months.
- The service delivered care according to local and national policies which were evidence based. They had received accreditation for the evidence-based care, which was being delivered.
- We observed staff providing care, which was compassionate and engaged at a level, which was age appropriate. Children and their parents were involved in their care and told us they were given adequate amounts of information about their care and treatment.
- The service was responsive to the needs of those accessing the services. The individual needs of children and young people were being met and staff had attended courses to enable them to communicate with those that had hearing impairments.
- The service was well led at local ward/unit level and staff told us and we found the leadership above this level was also good.

However:

- Nurse and medical staffing did not meet requirements of the Royal College of Nursing (RCN) and Royal College for Paediatric and Child Health (RCPCH). Nurse staffing on the children's ward did not have an experienced member of staff on for each 24-hour period and did not provide at least one member of staff with advanced paediatric life support (APLS) or European paediatric life support (EPLS) qualification on each shift. There were insufficient members of the medical team to provide paediatric consultant cover seven days per week. In addition, consultant cover provided did not cover the busy 12 hour period up to 10pm.
- Despite the implementation of a sepsis management pathway by the trust in 2014, we found this had not been embedded. Children and young people were not screened for sepsis when observations had identified them as at risk of sepsis.
- There was a lack of awareness on the children's ward in relation to ligature risks, for example, we did not see a ligature risk assessment had been carried out and there were no ligature cutters immediately available in the ward area. There was no abduction policy, therefore were no assured that staff would know what actions to take in the eventuality of a missing child.
- We could not be assured that staff followed the did not attend (DNA) policy for the children's outpatient department, and there was no DNA monitoring of paediatric outpatients departments where children attended.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- Sepsis knowledge and management was poor within the children and young people's service. Only two members of staff had completed training in sepsis management, and we found patients
- were not always screened or treated in line with trust policy for sepsis.
- There was no abduction policy available for the neonatal unit or children's ward.
- Checks of the adult resuscitation equipment on the neonatal unit had not been consistently checked.
- Nurse staffing on the children's ward did not meet the Royal College of Nursing standards. There was not a band six nurse allocated to each shift or a nurse qualified in advanced paediatric life support (APLS) or European paediatric life support (EPLS).
- Staff in the children's outpatient department did not have EPLS qualification.
- Consultant medical staffing did not meet the Facing the Future standards set by the Royal College of Paediatrics and Child Health (RCPCH). However there was a known national recruitment issue in this area.
- There was no ligature risk assessment completed for the children's ward.

However:

- Staffing on the neonatal unit was in line with the British Association of Perinatal Medicine (BAPM) standards.
- Resuscitation equipment on the children's ward had been checked regularly and items were in date and ready for use.
- Staff demonstrated good knowledge and understanding in relation to incident reporting and learning from incidents.
- Staff used paediatric early warning scores (PEWS) and neonatal early warning scores (NEWS) to appropriately identify a deteriorating patient.

Incidents

- From July 2015 to July 2016 there were 377 incidents reported for the children and young people's service trust wide. Of these, 145 incidents were reported by the children's service at Pilgrim Hospital, the majority of which (126 incidents) were classified as no harm. There was one moderate incident and 18 low harm incidents.
- From July 2015 to July 2016 there were no never events reported for this service at this hospital. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There were no serious incidents for the service in the last 12 months. The last serious incident was reported in July 2014 and the outcomes of this serious incident were still outstanding. Serious incidents are events in health care where there was potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- There was a good incident reporting culture amongst staff and staff told us they received feedback from reported incidents.
- There was evidence of learning from incidents, which occurred at the hospital through changes in guidelines and policies. Staff on the children's ward told us they only heard about incidents from their own hospital, which had potential for shared learning.
- Staff on the neonatal unit told us they experienced shared learning from incidents, which happened on the neonatal unit at Lincoln County Hospital, which had potential learning points to implement in their unit. We saw evidence of minutes from meetings and newsletters, which confirmed this.
- We saw evidence of perinatal (the period immediately pre and post birth) morbidity and mortality meetings which demonstrated on-going learning for future incidents. Mortality and morbidity meetings give health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. There had been no incidents reported requiring duty of candour in the last 12 months.

- All staff were aware of the requirements for being open and honest and would use the principles of duty of candour when dealing with any incidents. An example discussed by staff was around medication errors and being open and honest with the parents and carers of a child involved in this. Any discussions with parents, carers or the child themselves would be documented in their records.

Safety Thermometer

- NHS safety thermometer programme is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. Data is collected on a specific day each month to indicate performance in four key safety areas, which are new pressure ulcers, catheter associated urinary tract infections (CAUTI), venous thromboembolism (VTE) and falls.
- Data from the Patient Safety Thermometer showed that there were no pressure ulcers, falls with harm, venous thromboembolism or catheter urinary tract infections between July 2015 and July 2016.

Cleanliness, infection control and hygiene

- All areas we visited appeared visibly clean and clutter free.
- There were no reported cases of MRSA bacteraemia between January and June 2016. MRSA is a bacterium resistant to some widely used antibiotics.
- There were no reported cases of Clostridium difficile (C. difficile) between January and June 2016. C. difficile is a bacterium that can infect a person's bowels. It was also commonly associated with people who have had courses of antibiotics but can also be easily transmitted to other people.
- Hand hygiene audits were conducted monthly and information provided by the trust showed variable levels of compliance. The children's ward showed compliance rates between 80% to 100% between January and June 2016. During our inspection, we saw evidence of staff performing hand hygiene in accordance with the World Health Organisations (WHO) five moments for hand hygiene.
- Recent quality performance data for September 2016 showed the neonatal unit had achieved 100% in their hand hygiene audit.
- All staff were observed complying with the bare below elbow policy in the clinical environment.
- There were cleaning schedules available for domestic staff; however, we did not find evidence of all tasks being signed once completed. The only task, which had been signed off each day, was the flushing of the water outlets, as part of the Legionella policy. Legionella is a bacteria which can be found in water sources.
- Decontamination of equipment occurred after use with universal wipes. 'I am clean' stickers were placed on items once decontaminated to show that they were ready to use again. No items with 'I am clean' stickers were found to be dirty.
- Infection prevention and control risk assessments were conducted on admission. This included MRSA assessment, diarrhoeal disease assessment and Carbapenem resistant organism (CRO) assessment. CROs are organisms, which is highly resistant to a wide range of antibiotics including Carbapenems, which are usually used to treat serious infections and can be easily spread between patents if careful infection control practices are not carried out.
- All of the sinks which were designated as clinical hand washing sinks on the children's ward did not conform to the Health Building Note (HBN) 00-09 infection control in the built environment standards as they were not stand alone units.
- Hand washing facilities were available in all rooms and bays on the children's ward. Alcohol hand rub was not directly available at the point of care and staff did not have access to small bottles, which they could carry around with them. It was noted that some bottles of hand rub were available in clinical areas but located at clinical hand wash sinks next to the soap. This could cause confusion in staff who inadvertently could use the wrong product and therefore not effectively clean their hands.
- All toys belonging to the service were cleaned after use by using the universal wipes available on the wards. Toys were also on a deep clean rota where a further, more thorough clean was performed weekly and staff were required to sign when this had been completed. We saw evidence of staff signing these sheets when cleaning had taken place.
- There were some fabric toys available on the children's ward. Staff told us if a child was given a fabric toy, this would usually be kept by the child, and was then taken home by them. Fabric toys are not played with by more than one child.

- Single use items on some of the resuscitation trolleys were opened and left in the trolley. Staff told us this was how they checked the items were working. Packaging for these items should not be opened unless required to use them due to the risk of an item becoming contaminated.

Environment and equipment

- The children's ward and neonatal unit were noted to be very secure. Swipe access was required to enter and leave the areas. The main entrance for the neonatal unit was through the maternity building and was not clearly signposted. This resulted in difficulties in gaining access to the unit at times during the inspection however; parents were made aware of the correct entrance on initial admission to the unit.
- There was equipment recorded on the risk register as reaching the end of their life span and were no longer under a warranty/manufacturer's warranty. These items had been placed on a replacement plan. Clinical engineering department had oversight of this plan.
- We found equipment, which had no evidence of the last service in addition to broken equipment on the neonatal unit. We were not assured this was suitable for use. We reported these items to clinical engineering at the time of inspection and they were immediately rectified.
- We saw evidence of the resuscitation equipment on the children's ward having daily checks. No items were found to be out of date, and the ward had already identified and highlighted items which were due for replacement at the end of the month.
- The neonatal ward had adult resuscitation equipment available. There were inconsistencies in the checking of this equipment for example were saw completed daily checks for October 2016 but checks were missing between April and September 2016.
- Resuscitation equipment in adult outpatient departments where children visited was not standardised. We asked the trust for the paediatric resuscitation policy, however the information provided did not reflect a policy for staff to follow, the information contained details of advanced paediatric life support algorithms, so we could not confirm what paediatric resuscitation equipment areas should have.
- There was no ligature assessment for the children's ward despite the ward admitting children and young people with mental health problems including suicidal ideation and self-harm. This was escalated to the executive team during inspection and we received confirmation from the trust following our inspection that this had been rectified.
- There was an internal transfer transport incubator located on the neonatal unit. We saw evidence this had been checked daily. The transport incubator also had its own 'grab bag' of essential safety items, which may be required during transfers of babies. We saw evidence that this had been checked daily. All items were in date and ready for use.
- There was an isolation room available on the neonatal unit, which was used as a storeroom when there was no baby requiring the room. On the unannounced inspection, we saw the room had been emptied to maintain the cleanliness of the room.
- All windows in the children's ward had window restrictors in place, restricting the opening to 10 centimeters in accordance with Health Building Note (HBN) 00-10 part D: windows and associated hardware.
- The playroom for the younger children was noted to have plug sockets that were uncovered. This was a safety risk to small children. This was highlighted to a member of staff at the time of inspection. There were no other safety risks identified on the ward.
- There was a separate room on the children's ward for the older children to use. This room had age appropriate equipment in them for stimulation whilst admitted on to the ward.
- Staff told us there was enough equipment available in the hospital for them to be able to provide care. If there were any items of specialist equipment required for a patient, there were contracts arranged with companies to provide this equipment. Staff said the specialist equipment was usually delivered quickly.
- Staff took grab bags containing emergency equipment with them to the operating theatre when collecting a child. There were no checklists available for these bags and there was no documented evidence that these bags had been checked. On further investigation, we found four airways that were out of date and one airway, which had been opened. We raised this with the nurse in charge and this was immediately rectified.
- There was no separate recovery room for children and young people to recover after surgery, however there was one bay, which was used predominantly for them. This area however was not child friendly with little decoration on the walls for child stimulation.

Services for children and young people

Medicines

- There was a specific gentamicin (antibiotic) prescription chart used on the neonatal unit to minimise prescribing errors. Information received from the trust showed continuous 100% compliance with gentamicin prescribing.
- We reviewed 12 medication administration records (MARs). All MARs had evidence of a weight recorded which could be used for paediatric prescribing of medications. All prescriptions were signed and dated by medical staff, and there was evidence of all charts having allergies recorded or the box for no known allergies ticked if this was the case. One chart had no evidence of indication for antimicrobial use (reason for administering an antibiotic).
- Audit results provided by the hospital identified generally good prescribing practices. The compliance level was set at 100% for all aspects of prescribing, areas which did not meet this was demographics, allergy box, start/stop dates, frequency, clinical indication and maximum dosage for as required drugs. The author of the audit identified a re-audit would be required in 12 months to see if improvements in prescribing had been completed. As there was no date on the audit, we were unable to identify when this would be conducted and no action plan was provided to show what actions would be taken to improve practice.
- A paediatric pharmacist visited the ward daily. They were able to provide advice for medical staff on paediatric prescribing as well as reviewing medication charts of those admitted. They assisted with investigating medication incidents if they occurred.
- We requested antimicrobial audits for the children and young people's service however, the information was not provided, as the hospital did not complete antimicrobial audits for this service. Antimicrobial audits are specific audits for the correct use of antibiotics.
- We requested data for missed doses audits for the children and young people's service however the information was not provided, as the hospital did not complete missed dose audits for this service.
- We found evidence of medication refrigerators receiving daily checks of their temperature. Staff were aware of what steps required if they found a refrigerator out of temperature range.
- Controlled drugs (CD) are medicines that require additional security and regular checks. During our inspection, we reviewed records on the children's ward and neonatal unit, which demonstrated daily CD checks.
- Medicines were in date, and were located in locked cupboards or refrigerators and the nurse in-charge held the keys to the CD cupboard.
- The nurse led ward attenders service had access to adrenaline, which they would give to patients if they experienced anaphylaxis during their attendance. The adrenaline was in vials, which the nurse would draw up rather than pre-prepared injections.

Records

- Records were used by all members of the multi-disciplinary team and were paper based.
- Patient records were kept in trolleys, which were located at the main nurse's station; however, these trolleys were not locked. In the children's ward, the area where these trolleys were kept was accessible by the public, although there was usually a member of staff in the vicinity observing the trolleys.
- Records did not comply with guidelines on record keeping published by the General Medical Council and the Nursing and Midwifery Council Of the six complete sets of records we reviewed, none of the records had signed entries or the designation of the person writing the entry recorded.
- Audit results provided by the trust found similar issues. They also highlighted an improvement in designation and signature on each entry was required, as well as improvements in investigation documentation, patient details on each page and drawing a line through empty spaces. The author of the audit report recommended this should be repeated in 12 months to identify if improvements had been made. As there was no date on the audit, it was difficult to identify when a re-audit would be due. An action plan was not forwarded to show how the service would improve practice.
- There was evidence of clinical risk assessments being completed, which included bed rails assessment, pressure ulcer assessment, and infection prevention and control clinical risk assessments.
- There were no printed handover sheets for the nursing handover process on the children's ward or neonatal

unit and no accountability handover documentation sheets. If there were any concerns over a specific handover, there was no auditable trail and no ability to check the information handed over.
- There was a flag system available on the computer admission system at the hospital, which identified children who were at risk and for 'looked after children' (LAC). The medical records also contained details around the specific risks of the child and any action plans, which were in place.

Safeguarding

- Staff we spoke with were knowledgeable about safeguarding issues and support that was available. Staff described how they would make a safeguarding referral and named members of the safeguarding team they could approach.
- A trust safeguarding children and young people policy was available for review. This was due to be updated in September 2016.
- Information provided by the trust showed 74% of staff on the children's ward and 95% on the neonatal unit had completed their safeguarding children level three training. Although the neonatal unit had achieved the trust training target, neither area met the requirement of the intercollegiate guidance which requires all staff that have contact with children and young people to have level three safeguarding training in children.
- The safeguarding team were in the process of re-launching safeguarding champions on the ward. The champions on the ward would be a safeguarding resource for the ward and would attend meetings and training to enhance their knowledge.
- The training lead for neonatal and paediatric trainees told us they had instigated monthly safeguarding supervision as part of the training programme. These sessions were not minuted, but feedback from trainees had been positive about these sessions and had been a good opportunity for individuals to discuss complex and upsetting cases, and also learn from others how to manage safeguarding cases.
- There was a dedicated examination room for procedures relating to child sexual abuse located on the children's ward, with one paediatrician from the hospital designated to perform such examinations. When not in use, the room was locked to prevent unauthorised use. All material related to examinations was securely stored away from the room in accordance with information governance and confidentiality policies.
- Information provided by the hospital showed there was an incident where a sexual abuse examination was required, but there was no staff member available to conduct this. The child was transferred to the closest hospital that had the provisions to conduct the examination. Staff told us this was an exception as there are two paediatricians available trust wide who can conduct the examinations and they always try to make sure that one of them was available.
- The safeguarding report 2014/15 reported that the trust had forwarded details of three cases of female genital mutilation (FGM) to the home office. The trust have reported a total of eight cases of FGM to the home office for 2016/17 of which six were type four and two type one cases. Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons. Since October 2015, it is mandatory for regulated health and social care professionals to report known cases of FGM, in persons under the age of 18, to the police. There were four types of FGM which healthcare professionals are required to report.
- The trust conducted PREVENT training for staff. PREVENT training was conducted to highlight the risk of terrorism and radicalisation. Since the training began in 2014, there had been no cases referred by the safeguarding team for suspected terror or radicalisation cases.
- There was no abduction policy for staff in the children and young people's service to follow. Staff members were however, able to provide details of steps they would take in the event of a child or young person going missing in their ward areas.
- For babies admitted to the neonatal unit, if there had been safeguarding concerns raised during the mother's pregnancy, details of such would be kept on a safeguarding database which was accessible by staff from the neonatal unit. There would also be details on the computer admission system that would identify this, as well as records kept in the medical notes of the mother and the child once they had been born.
- Staff on the neonatal unit would be notified of any occasions where a concealment of pregnancy had occurred at the hospital due to the increase in

probability that care of the baby would be required. Staff told us all babies born where there were concerns over the mother concealing the pregnancy would be reported to the safeguarding lead for assessment of risk.
- There was an alert system in place, which highlighted to staff if a child or young person had known safeguarding concerns or alerts in place. The flagging system had different categories to identify what safeguarding issue were related to the individual, examples included child sexual exploitation and missing person.

Mandatory training

- All staff told us they had no problems attending mandatory training sessions.
- The trust mandatory training compliance target was 95%.
- Information provided by the trust showed the children's ward had an 83% compliance rate with mandatory training in October 2016. This however included members of staff who were off for maternity leave. This did not meet the trusts own target of 95%.
- Information supplied by the trust showed the neonatal service had a 95% overall compliance rate with mandatory training. Although this meant they had achieved the trusts own target, there were subjects, which individually did not meet the 95% compliance rate, these were infection control, information governance and basic life support.
- Two members of nursing staff from the children's ward had completed sepsis training. Information provided by the trust informed us they planned to increase this. This did not provide assurance that staff were knowledgeable in sepsis management.

Assessing and responding to patient risk

- A sepsis bundle was introduced into the service in 2014 and information provided by the trust showed that this was embedded and had been working well. Sepsis is a life threatening condition that arises when the body's response to infection injures its own tissues and organs. Audit results from January 2016 showed 60% of those treated for sepsis fulfilled the criteria. None of the patients received antibiotics within one hour and no patients received oxygen therapy, which are both critical elements of sepsis treatment. Of the 10 patients included in this audit, one patient had a sepsis screening form completed. Observations were not performed in accordance to the severity of the illness that the child was experiencing and did not reflect actions in accordance with the paediatric early warning score (PEWS). The positive results of the audit were all those included in the audit had blood cultures performed and when antibiotics were given; these were in accordance with trust policy.
- We found there were two patients who were being treated for sepsis within the service; however, there had been no evidence of sepsis screening for these patients. Senior staff members told us they thought sepsis awareness and management of sepsis was generally good amongst staff, however the use of the screening tool was poor and they intended to focus on this in the upcoming months.
- During the unannounced visit, we found a child that had been admitted with two clinical indicators of sepsis; however, they had not been screened for sepsis. This was raised with the ward manager at the time.
- The service used the World Health Organisation (WHO) surgical safety checklists for children and young people who underwent a surgical procedure. Audit results showed that Pilgrim Hospital achieved 99% compliance in February 2016. The results could not be broken down to show compliance standards for the Children and Young people's service.
- The paediatric early warning score (PEWS) and the neonatal early warning score (NEWS) were additional tools used to monitor children and babies who were at risk of deterioration to record routine physiological observations such as blood pressure, temperature, respiratory rate and heart rate. PEWS and NEWS were used to identify where escalation to medical teams was required.
- We reviewed 12 PEWS and NEWS charts. All scores had been correctly calculated on the charts. None of the charts reviewed had identified a child requiring escalation. This snap shot review of PEWS and NEWS charts showed an improvement from the results of an audit conducted by the hospital from September 2015 to August 2016, where only 78% of charts had a score recorded.
- Staff on the neonatal unit demonstrated how they had responded to a risk when a baby who was a twin had started vomiting spontaneously, despite no trigger on the NEWS chart. As staff were unsure what had caused

this sudden deterioration in the baby's condition, they escalated the other baby for immediate review by the medical team, and treatment for both infants was commenced.

- Staff told us they also used their own clinical judgement for escalating concerns about a child or young person to the medical team. An example of this was a child who was not triggering on the PEWS chart for immediate escalation, however as they had scored a maximum score for their temperature and a moderate score for their heart rate, the nurse escalated this to the medical team for potential sepsis screening.
- A qualified nurse who took emergency equipment with them collected children and young people returning from theatre. Oxygen was provided by the theatres for the journey back to the ward; however, there was no suction equipment, which was not in accordance with RCN standards for transferring children to and from theatre. On our unannounced visit, it was observed that suction equipment was still not available. Staff told us they were waiting for a decision to be made whether suction equipment should be carried when returning a child form theatre.
- Staff completed a checklist for all admitted to the ward due to self-harm. The checklist assessed the risk that these individuals posed. The main form, which was required, was to assess whether the individual would require one to one observation whilst admitted on the ward.
- No staff in the radiology department were in-date with paediatric intermediate life support (PILS), however all staff were in date with paediatric basic life support. This meant if a child or young person deteriorated or had a cardiac arrest in the radiology department staff would only be able to provide basic lifesaving skills until a more qualified team arrived.
- There was a transfer policy in place for children or young people who required a high level of care that could be provided at the hospital. For children that required transfer to a different hospital, staff from the ward would accompany the child if they were not ventilated (a tube inserted into the trachea to provide oxygen to the lungs). If the child was ventilated prior to transfer, the retrieval team would transfer the child themselves. For neonates requiring transfer to a different hospital, a transport team would be responsible for collecting the infant and transferring them to the receiving hospital.

Nursing staffing

- Nurse staffing did not meet the Royal College of Nursing (RCN) guidance as the children's ward failed to provide a band six nurse on all shifts. We reviewed a selection of rota's which showed the ward had concentrated on providing a band six nurse on daytime shifts, however there was a noticeable reduction in band six cover for night shifts. In July 2016, we saw 29% of the night shifts had a band six on duty and in September 2016 43% of night shifts had a band six on duty. Where there were no band six nurses present on day shifts, this gap was covered by the band seven-ward manager stepping in to provide any senior nurse assistance.
- There were eight members of staff on the children's ward with European paediatric life support (EPLS) and three other staff members identified to attend a course in November 2016. Staff told us they required 12 members of staff to be EPLS or advanced paediatric life support (APLS) qualified to assure cover was provided for each shift, this did not meet the RCN core standards.
- At the time of our inspection nurse, staffing levels on the children's ward were planned in line with RCN guidance. For example there was a ratio of one nurse to three children under the age of two years, and one nurse to four children above the age of two.
- Staffing on the children's ward had been a long standing problem. The ward was established for 24.05 whole time equivalent (WTE) band five nurses, however they only had half this amount (12.22 WTE). To try and work around this issue, the ward manager had increased the number of nursery nurses for the ward (band four staff). The ward manager had a rolling advert for band five posts but told us recruiting into this position had been difficult.
- During our inspection, we found planned staffing for the children's ward met the actual staff present for the shift.
- The children's ward had one part time qualified play specialist, who worked three set days a week. They were involved with providing activities to children admitted on the ward, preparing children who were going to theatre and offered children attending the hospital for a pre-operative assessment the opportunity to look round the ward.
- There were three nursing handovers each day. During the inspection we observed a nursing handover on the children's ward. The staff did not use a printed handover

sheet for their handovers, however the information provided was detailed and oncoming staff were given the opportunity to ask the staff for further information if required.

- Between April 2015 and March 2016, the hospital reported bank and agency use of 1% in children's services. This was lower than the agency and bank usage rate for other locations at the trust.
- Feedback from staff had highlighted there were general concerns about the number of staff leaving, however data provided by the hospital showed a turnover rate of 10% in June 2016, which was lower than the turnover rate for other locations at the trust.
- There were no members of staff in the children's outpatient department in date with their EPLS or APLS. Assurance of safe care and treatment of a paediatric patient in cardiac arrest could therefore not be assured.
- A new policy had been drafted to escalate any staffing concerns in the neonatal unit. This used a red, amber and green (RAG) rating to identify the severity of the staffing issues with green having minor impacts on staffing and red being the most severe impact on staffing.
- Nurse staffing on the neonatal unit was planned based on the British Association of Perinatal Medicine (BAPM) and RCN guidance. On each shift there were three registered staff and one unregistered member of staff, with at least one registered member of staff qualified in neonatal nursing (qualified in speciality). These standards were applied to both day and night shifts and the rotas we reviewed reflected this.
- On our inspection, we found the actual staffing to reflect the planned staffing for the neonatal unit.
- All neonatal staff in post for a year had completed the neonatal life support training; this provided assurance there would be suitably qualified staff on each shift.
- The nurse in-charge of the shift in the neonatal unit was a supernumerary member of staff and therefore did not have their own infants to look after.
- The transitional care bay of four cots was covered by a member of staff from the maternity department during the day, and a member of staff from the neonatal unit on the night shift. This did not impact on the staff to infant ratio for the main neonatal unit. Transitional care was provided for infants that required nursing care and monitoring, however not to the level provided by a neonatal unit or special care baby unit.

Medical staffing

- The Royal College for Paediatric and Child Health (RCPCH) facing the future: standards for acute general paediatric services were not completely met at the hospital. There were five consultant paediatricians working at this hospital. They had implemented the consultant of the week model which they had called 'hot week consultant'; however the presence of the consultant on site was from 9am to 5.30pm, Monday to Friday, and 8.30am to 1pm on Saturday and Sunday.
- The hot week consultant model ensured good handovers and improved communication with children and their families, as well as being able to provide better supervision for trainee doctors.
- There was not a consultant paediatrician available in the hospital during the times of peak activity (12 hours a day with extended evening work to 10pm), seven days a week. Consultants were accessible on the telephone if required beyond the time of 5.30pm and were able to get to the hospital within 30 minutes if required.
- There was one physical medical handover each day. Staff said this was very informative, run well and was consultant led. There was consultant to consultant hand over each afternoon conducted either by telephone call or text. This did not meet standard four of the RCPCH standards for acute general paediatric services which suggested there should be at least two physical handovers each day.
- There was one handover for the neonatal service in the morning which was consultant led. There were no standards related to the number of handovers which a neonatal unit should have, however the British Association of Perinatal Medicine recommends two consultant led ward rounds each day.
- Consultant led ward rounds were conducted seven days a week on the children's ward and twice a week on the neonatal unit. During our inspection, we observed a ward round being conducted on the neonatal unit.
- The registrar (middle grade doctors) rota comprised of a one in eight shift pattern for ward cover and comprised of two rotational trainee doctors from the training scheme and six speciality doctors.
- Rotas provided by the hospital showed there were two registrars available on day shifts Monday to Friday who individually covered the children's ward or the neonatal

unit. A third registrar was occasionally used to cover clinics. Out of hours and on weekend day shifts, one registrar was used to cover both the children's ward and neonatal unit.
- Locum registrars were used regularly at the hospital. Rotas provided by the hospital for October 2016 showed that locums covered around 10% of the shifts, which was a similar trend for the previous three months.
- The senior house officer (SHO) or tier one rota had a one in eight full shift paediatric ward cover and comprised of five trainees, two foundation year two level doctors and one speciality doctor.

Major incident awareness and training

- The service had their own winter management plan which included business continuity plans to cover increase in attendance for winter related illnesses in children, such as bronchiolitis. Staff did however tell us they would need to review this policy, but it had previously worked well when implemented.
- When asked about major incident policies and training for this, staff were unaware of this and had not received any specific training.
- Staff had attended fire training as part of their mandatory training; however they had not completed any practical training for ward evacuations. Staff told us they would know what to do in the event of a fire as the classroom training was very detailed.

Are services for children and young people effective?

Good

We rated effective as good because:

- The service were following evidence based policies and guidance. A selection of policies reviewed were all in date.
- There was evidence of regular pain assessments of children and young people and appropriate actions taken for a child in pain.
- There was a supportive training programme for medical trainees within this service.
- The service had achieved level one accreditation of the UNICEF baby initiative and participated in the BLISS baby charter.
- There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health professionals.

Evidence-based care and treatment

- The paediatric sepsis guidance was in line with the National Institute for Health and Care Excellence (NICE) clinical guidelines (CG) 160, however the guidance was not fully embedded in this service.
- All policies and guidelines controlled by the service were based on NICE and royal college guidelines. A selection of policies were reviewed and these were in date.
- Paediatric imaging guidelines were last reviewed in 2010. The radiology staff were currently reviewing these guidelines to make sure they reflect the most up-to-date evidence-based practice. We found up-to-date paediatric exposure information displayed on the walls of all rooms where imaging took place.
- All staff were involved in local audit activity. The audits conducted were gentamicin audits, paediatric early warning scores (PEWS) and neonatal early warning scores (NEWS audit, infection prevention and control audits and documentation audits.
- The neonatal unit had achieved level one of the UNICEF baby friendly initiative which was aimed at supporting breast feeding and improving parent-infant relationships by working with public services to improve standards of care.
- The neonatal unit also participated in the BLISS baby charter, which was a practical guide for hospitals to enable them to provide the best possible family-centred care for premature and sick babies.
- The neonatal unit had an electronic noise monitor on the wall which monitored the level of noise in the unit. This item was implemented as evidence had proven too much noise in a neonatal unit can cause hearing damage to infants. The monitor had red, amber and green ratings to identify if the noise was at an acceptable level. The staff working in the unit tried to maintain a 'green' level which was deemed acceptable.

Pain relief

- Staff in the recovery area used the face, legs, activity, cry and consolability (FLACC) scale for assessing a child's pain, post-surgery. Staff found this to be the most effective way of assessing for pain post-surgery after trialling other pain scales.

- Staff on the wards used a numerical pain score of zero to three for older children and a faces chart which corresponds with a numerical pain score for younger children. We saw a young child who had returned from theatre having a pain assessment conducted. As the child was scoring a three, nurses responded appropriately by administering pain medication to the child.
- We saw evidence of a neonatal pain assessment tool used to assess pain in infants. This recognised that infants can experience pain as any other child or young person could, and the tool used helped staff to identify when an infant was in pain. The three neonatal pain assessment tools we looked at had not identified any of the infants in pain, and no follow up pain medication was therefore required.

Nutrition and hydration

- Children and young people returning from theatre were offered food and drink as soon as they were orientated enough. Children told us they were offered a range of items to eat and the food was usually nice.
- All children received an initial review of their dietary requirements on admission. If there were concerns about the child's nutritional status, a referral was made to the dietitian.
- Infants admitted in the neonatal unit were on feeding charts to monitor their milk input. This was a vital chart to demonstrate whether the infant's clinical condition was improving or deteriorating.
- For infants having formula milk (also known as infant formula or baby milk), there was a provision of milk available for them and a selection of bottles and teats to use.
- Infants receiving breast milk, the neonatal unit provided equipment to enable mothers to express their milk and a dedicated milk refrigerator for them to store it in. This refrigerator was locked at all times, and we saw evidence of staff regularly monitoring the temperature.
- There was not a breast feeding specialist for the hospital and there was no link nurse or champion for breast feeding on the children's ward. If breast feeding mothers had difficulty, staff would ask the midwives from the maternity unit or neonatal staff for help and advice.

Patient outcomes

- The trust performed equal to or better than the national average in nine out of 12 audit outcomes in the national neonatal audit programme (NNAP). It was noted that in the 2016 NNAP, two additional audit criteria were added, these were provision of magnesium sulphate to mothers 24 hours after giving birth to babies below 30 weeks of gestation and numbers of babies with a positive culture growth from a central line (a catheter inserted into a large vein which usually delivers medication or fluid) after 72 hours of life (measures per 1000 line days). We did not see an action plan to address how the trust could improve on the outcomes which were worse than the England average.
- Information provided by the hospital showed they performed similar to the England average in the 2014/15 paediatric diabetes audit.
- The neonatal unit had been piloting oxygen saturation levels screening for the last 12 months. This screening was conducted at the same time as the infant audiology screen. The pilot at the time of our inspection had identified infants that required treatment for sepsis which potentially may not have been identified.
- Newborn and infant physical examination (NIPE) screening was a national screening programme provided to all newborns and should be performed within the first 72 hours after birth. The neonatal unit had improved their performance with this screening programme from 72% to 96%. This meant the neonatal unit were achieving the national standard.
- The neonatal unit had audited their sepsis performance against neonatal NICE guidance and achieved 92% compliance.
- An audit of the management of croup in January to February 2016 was performed. Results showed staff were not following the guidelines provided for them by neighbouring trust with the exception of following the discharge criteria. Recommendations of the audit were to make the guidelines more readily available or consider devising a set of guidelines of their own to follow. Once the recommendations had been followed through, a re-audit of the same criteria was recommended for 12 months' time.
- There were no emergency readmissions after elective admission at the trust for children under one years of age between March 2015 and February 2016.
- The emergency readmission rate after emergency admission at the trust for children under one years of age was better than the England average between March 2015 and February 2016.

- The emergency readmission rate after emergency admission at the trust for children between the age of one and 17 in both paediatric and general surgery specialities was better than the England average between March 2015 and February 2016.

Competent staff

- Updated staff appraisal rates for October 2016 were recorded as 81% for the children's ward and 82% for the neonatal unit. This fell below the trust target of 95%.
- There was no formal clinical supervision sessions (an activity that included skilled supervisors and practitioners to reflect upon their practice) provided for staff working within the service. If staff felt they needed to debrief or reflect on experiences, they would do so informally amongst their peers.
- The medical trainees had a supportive training programme and the lead for the service had received recognition from peers and trainees that the programme had improved.
- The lead for training in the service provides two hours of teaching per week. Staff told us they are able to attend this protected teaching most of the time uninterrupted. This training was mainly for medical staff; however nursing staff were invited to selected sessions.
- There was a rigorous process for medical revalidation through portfolio reviews and appraisals. There was currently one medical appraiser due to consultants leaving the hospital.
- There was an induction process for locum doctors who worked at the hospital. Before they arrive at the hospital, they were required to send their curriculum vitae through to the head of service who would assess them for suitability for the position.
- There were no staff qualified in European paediatric life support (EPLS) or advanced paediatric life support (APLS) in the children's outpatient department. Similarly, there were no members of staff in adult outpatient departments or radiology department with any advanced paediatric life support skills.
- There were 10 staff with high dependency competency skills to care for a child admitted into a high dependency bed on the children's ward. Staff told us a band five nurse would usually take the lead for caring for a high dependency child, with the support of a competent and experienced band six nurse. All children requiring transfer to a paediatric intensive care unit (PICU) would be cared for in the high dependency bed on the children's ward until the retrieval team collected them.
- There was no competency package for new starters on the children's ward. New starters were required to complete their trust induction and were supernumerary on the ward for one month, working alongside experienced staff. The clinical educator was looking into devising a competency package for new starters.
- There was a practice development nurse (PDN) and clinical educator who worked with staff in the neonatal unit to provide additional training. Sessions were available for staff working in neonatal units across the trust and the PDN would alternate the location where this would take place.
- Simulation training for neonatal staff was provided by two members of staff who had attended the simulation course. These sessions were seen as vital sessions, staff were placed into a realistic scenario and worked through what they would do, then receive feedback on their performance.
- There were two universities identified by the trust for specialist neonatal training. As one of the universities was fully subscribed, potential staff would not be able to attend that course until at least September 2017, the staff were therefore allocated to the alternative university course although this was not the preferred course.
- The training leads for the neonatal unit also provided in-house transport education which was aimed at improving knowledge, competence and confidence in staff when transporting a sick neonate. This training would occasionally be linked with the transport network who provided the transportation for the hospital.
- New nursing staff working on the neonatal unit received an induction programme which linked in with the induction programme used by another trust with neonatal services. Staff felt this induction programme was comprehensive and prepared them for working on the neonatal unit.
- The clinical educator had developed an induction pack for student nurses and midwives who completed a placement on the neonatal unit. This pack included useful information on staffing and terminology commonly used on the unit. This pack had been implemented trust wide.

- Discharges from the children and young people's service were only performed by registrars (middle grade doctors) or consultant paediatricians.
- Nursing staff told us there had been training sessions provided by the hospital to help them with the Nursing and Midwifery Council (NMC) revalidation process. A member of staff had recently successfully validated and was now providing support to other members of staff.

Multidisciplinary working

- Staff told us they worked well with other members of the multidisciplinary team (MDT) which included physiotherapists and occupational therapists (OTs). During our unannounced inspection we saw staff working well with a physiotherapist who was required to review a patient.
- Staff told us they were able to request additional specialist physiotherapy support for children if this could not be provided by the hospitals own physiotherapy staff. We saw evidence of this during our inspection. The working relationship observed between hospital staff and the external member of staff was very positive and focussed around the needs of the child.
- Regular MDT meetings were conducted on the ward to discuss the care for each child and any potential ongoing requirements once discharged from the ward. Members of the MDT meetings include nursing staff, doctors, physiotherapists, OTs, dietitians, school nurses, health visitors and GPs. If required other members of the team including social workers can be invited.
- The service had good links with other hospitals which provided specialist advice on cases. Facilities available in the neonatal unit at Lincoln which was accessed by the Boston staff enabled medical staff to directly link with other hospitals to review scans and other medical information on a patient enabling rapid specialist advice to be gained.
- There was one qualified play specialist who provided services on the children's ward. Due to limited staff availability, they were unable to visit any other areas where children may be present, which included the outpatient departments, ED and radiology.
- Young people transitioning from the paediatric diabetes clinic undertook a transition period of 12 months and followed the trusts paediatric diabetes multidisciplinary services transition policy. The paediatric consultant transferred the young person to the transition clinic where both paediatric and adult teams were involved in the care and treatment plans and worked alongside each other.
- Staff told us there was work being completed to arrange MDT between paediatric consultants and ear, nose and throat (ENT) specialists. It was hoped that paediatric consultants would attend the ENT clinics which children attended.
- Staff from adult outpatient areas where children may attend appointments felt they had a good relationship with the children's ward and would feel confident contacting them if help was required.

Seven-day services

- After 5.30pm Monday to Friday and after 1pm on a Saturday and Sunday, out of hours consultant cover was provided off site and were accessible through telephone communication which went through the hospital switchboard. All consultants lived within 30 minutes of the hospital so would be able to attend promptly if there was a situation which required their physical presence.
- Staff told us there was access to physiotherapy out of hours for children with complex needs and medical conditions such as cystic fibrosis.
- There was 24 hour access to the radiology department, seven days a week. Staff reported concerns over the accessibility of this service.
- There was no paediatric specific pharmacy service out of hours or at the weekends. If any pharmacy issues were identified, the service would be required to contact the out of hour's service that was provided for the whole of the hospital.
- There was no senior nurse rota for paediatric cover out of hours. Staff told us they were encouraged to contact their managers or matron in exceptional circumstances or use the site managers in first instance.

Access to information

- Staff in the children's outpatient department told us they regularly had difficulties in accessing medical records required for clinics. Records often turned up late for the clinics which made it difficult for the doctor reviewing the child. Incidents had been raised about this, but access to records had not improved.
- Staff told us they did not use the personal child health record (PCHR) regularly unless they administered a

vaccination to the child or young person in which case they would enter the details in the record. We did, however see evidence of the growth charts found in the PCHR in the medical notes of those children and young people admitted into the ward areas. These were updated when or if the child was admitted or seen in an outpatient clinic. Staff were unsure if this information was transferred into the child's PCHR.

- The service had an electronic system which provided the GPs, health visitors and school nurses with an electronic copy of the child or young person's discharge letter.
- GPs had direct access to the doctors and nursing staff if they wanted advice about a child's care or treatment. Staff told us they thought the direct access between the hospital and GPs had helped to improve the relationship and the communication between them.

Consent

- Knowledge around seeking consent from young mothers (14-16 year olds) and mothers who may not have capacity to provide consent was variable. A member of staff was unsure of what steps they would take if there were concerns about a mother's capacity or ability to provide consent. A different member of staff however was able to tell us what they would do if they found themselves in this situation and provided a recent example of where this was required.
- Information provided by the trust showed 61% of staff on the children's ward and 70% of staff on the neonatal unit had completed their Mental Capacity Act training at the end of September 2016. This did not meet the trust training compliance rate of 95%.
- The trust's consent for examination and treatment policy supported making the patient's best interests central to the process of obtaining consent. If a young person was under 18 and wished to consent to their own treatment, staff followed Gillick Competency to assess whether the young person would have the maturity and intelligence to understand the risks and nature of treatments. The young person would be given time to consider all the options. Staff on the children's ward told us they would encourage all young people to be involved in their consenting process.
- We observed as part of one preoperative child's journey that both the surgeon and anaesthetist explained the procedure, checked the parents and child's understanding of the procedure and confirmed that written consent had been obtained
- There was no evidence of consent being provided for babies who were undergoing procedures on the neonatal unit. Staff told us the only procedure which required formal consent to be provided was for retinopathy of prematurity (ROP) screening. There was however evidence in the medical notes of staff communicating with parents about any upcoming procedures or informing them when procedures had been completed.
- The annual consent audit, completed in July 2016 showed the service was compliant with 20 out of the 29 standards. One of the standards showed the service completed 100% of consent forms in advance of the procedure being conducted. The action plan which accompanied this recommended that all consent should be reconfirmed on the day of the procedure. Other areas which the audit results showed non-compliance against included copy of consent form given to parents, copy of the consent in the notes, leaflet provided to the parents/patient and special requirements recorded.
- Staff told us they had not received any restraint specific training at the trust however they completed conflict resolution training. They also told us they had not been in a situation where they would require restraint techniques to be applied.

Are services for children and young people caring?

Good

We rated caring as good because:

- Parents and children that we spoke with were all complimentary about the care they received at this hospital.
- We saw evidence of compassionate care and emotional support provided to both the child and their relatives.
- Information about the care and treatment was provided for children at a level they understood, as well as their parents or carers.

However:

- We saw two examples of care being provided to children which did not respect their privacy and dignity.

Compassionate care

- The service had been selected to trial a new children's survey alongside some specialist children's hospitals. This trial was expected to last for up to four months and was completed using child friendly equipment online.
- The Friends and Family Test (FFT) was a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Information received showed the Friends and family test (FFT) results for the children's ward varied with between 60% and 100% of respondents recommending the NHS service they had received to friends and family who needed similar treatment or care. There were no responses available to explain the variable rate for this, however it was noted that the results were based on low response rates.
- Neonatal unit did not participate in the FFT, however they did ask the family/carers of babies to complete exit cards for feedback.
- The service at the trust performed better than other trusts in the CQC children's survey 2014 for the question that asked if they felt the people looking after them were friendly. The service performed about the same as the other trusts for the other 10 questions relating to compassionate care.
- Parents we spoke with were complimentary about the care their children received. Children themselves were also happy with the care provided by the staff. Comments included how the parents of children going to theatre had been "well looked after", "they couldn't fault the care given" and "it was great care".
- Children and young people received a bravery award following their surgery. Parents commented on how caring this was from the theatre staff,
- On return to the ward, all children were given the call bell so they could call for staff if they needed anything.
- During the inspection, we mainly saw children and young people having their dignity respected and maintained. However, there were two occasions where children were undergoing procedures which appeared distressing to them, but did not have their privacy maintained through the use of a curtain.
- Parents told us they were confident in the staffs' ability when they left the ward for short periods. They knew the ward was a safe place for their child and they had confidence in the staff.
- We tracked a child through the theatre pathway and found at every step staff provided care that was compassionate dignified and respected the child's privacy.
- Parents of infants discharging from the transitional care bay in the neonatal unit were provided feedback forms to complete about their experience of the service.

Understanding and involvement of patients and those close to them

- The trust performed about the same as other trusts for all 15 questions on the CQC's children's survey 2014 relating to understanding and involving patients and those close to them.
- Parents were happy with the amount of information they were provided with by all staff that were involved in their child's care. We observed that at each stage of the pathway for an elective child, the parents had information explained to them again and were given the option to ask questions if they were unsure about anything.
- One parent told us about staff returning after ward round to explain again what the doctor had said to make sure they understood what was happening.
- Parents told us all staff spoke with their child about any health issues and gave them the opportunity to ask their own questions.
- When speaking with the children, all staff spoke at a level which they could understand.

Emotional support

- The service at the trust performed worse than other trusts in the CQC children's survey 2014 for the question that asked if they were told different things by different people, which left them feeling confused.
- During the inspection, we observed staff providing support to a mother who had become emotional following discussion with the medical team. The member of staff was very quick to attend to the mother and provide the support that she required.
- Staff facilitated parents accompanying their child into the anaesthetic room and then joined them again in the recovery area after the operation to provide emotional support and comfort to the child.

Services for children and young people

Are services for children and young people responsive?

Good

We rated responsive as good because:

- There were facilities available for parents to stay with their child whilst they were admitted.
- The children's ward was taking steps to meet the individual needs of children admitted, which included staff members undertaking sign language courses and translating appointment letters for those whose first language was not English.
- The service was above the national standard for the 18 week referral to treat (RTT) for the surgical pathway and was the same as the national average for most of the medical pathways.
- Mothers who were breast feeding their children were offered a meal on the wards.

However:

- Further work was required for transition clinics due to the limited availability at the hospital.

We could not be assured that staff followed the DNA policy for the children's outpatient department, and there was no DNA monitoring of paediatric patients in departments where children attended.

Service planning and delivery to meet the needs of local people

- Significant improvements with the child and adolescent mental health service (CAMHS) service had seen a reduction in admissions to the children's ward for those children and young people experiencing mental health problems. The improvements included the introduction of a crisis response team and increased support for the ward area.
- The children's ward had one high dependency bed which was not commissioned at the time of inspection. However there was an identified demand for this provision. The hospital were currently in talks with their commissioners to officially commission this service after a gap analysis was completed. From December 2015 to November 2016 there were 40 admissions into the HDU bed.
- There was a separate waiting area for younger children in the children's outpatient department. This contained toys that were age appropriate, a television playing cartoons and seats which were suitable for young children to sit in. Older children (above the age of 10) could access this area; however there was a separate area where they could wait if they preferred.
- The trust provided a diabetes transitional clinic for those young people transitioning from adolescents to adulthood. This was the only clinic provided by the trust; however they had specialists from other hospitals that provided visiting transition clinics for other illnesses. An example of this was for young people with cystic fibrosis (CF). These transition clinics were held at the hospital four times a year. Young people were identified for transition clinic as they approached their 16th birthday.
- The children's ward regularly admitted children up to the age of 16 years old. After this, the young person was given the option of whether they were admitted on to the children's ward or an adult ward up to the age of 18. Staff told us the exception to this was for young people with complex needs who would be given the option to be cared for on the ward until they were 19 years old.
- The children's ward offered a ward attenders service which provided children and young people with a phlebotomy service (blood taking), allergy testing and vaccination service. This service was available three days a week.
- There were facilities available on both the children's ward and neonatal unit for families to use whilst their child was admitted. There were beds available for parents to use on the children's ward as well as an additional suite with bedrooms, wash facilities and a kitchen. On the neonatal unit, there was also a laptop available for families to use following feedback from a parent about the difficulties in arranging essential things like car insurance whilst their baby was admitted on the unit.
- There were facilities available in the children's outpatient department for families attending the department who had small children. This included baby

changing facilities which were visibly clean, and breast feeding rooms which maintained the privacy of women who needed to feed their small children whilst at the department.

Access and flow

- Information provided by the hospital showed the service was about the same as the England average for meeting the 18 week medical referral to treat (RTT). The areas which were worse than the national standard were paediatric urology and paediatric dermatology. Information around the surgical pathway and 18 week RTT data showed they were above the national standard, however the service was worse than the national standard for paediatric trauma and orthopaedics.
- There were delays in the paediatric cardiology speciality clinics due to staffing. This had resulted in a backlog of patients waiting for appointments. Staff told us work had been conducted to manage this backlog and the staffing of this clinic had improved. They predicted this backlog would be resolved in two months of our inspection and all patients had been risk assessed.
- The service had a process to monitor their 'did not attend' (DNA) patients in the children's outpatient department. If a child DNA to two appointments, staff would follow up the child to identify if there were any concerns. This also included informing the child's GP and the hospital safeguarding team.
- There were 1225 DNA appointments recorded in paediatric outpatients between November 2015 and October 2016. Of these appointments, 687 received a follow up appointment, with no further details of whether these appointments were attended. No details were provided on the other 538 appointments that were recorded as DNA; we therefore could not be assured the trust followed their own DNA policy.
- Information provided by the trust showed there was no process in place for following up children and young people in the adult outpatient department who DNA their appointments.
- Any child or young person who had their appointment cancelled would be given the opportunity to attend the next clinic available.
- Senior staff told us there was no process for identifying outliers within the hospital as there were no issues around capacity.
- Following a risk summit at the trust in July 2016, the children's ward was given the ability to flex the number of beds being used. Staff told us they tried not to do this often. However their main focus was the safety of the children on the ward and if they needed to reduce the number of beds to maintain a safe environment, they would. They were aware this could impact on other services such as the emergency department (ED).
- Between April 2015 and March 2016 the median length of stay for elective admitted patients under the age of one was similar to the England average. The median length of stay for emergency admitted children under the age of one was lower than the England average.
- Between April 2015 and March 2016 the median length of stay for elective and emergency admitted children aged between one and 17 years old was similar to the England average.
- Admissions into the children's ward came mainly from ED, however staff told us GPs could also directly refer a child to them for assessment and treatment.
- We requested information about paediatric outpatient clinics and whether they ran on time, and if not did they monitor any delays, however the trust did not provide us with this information. During our inspection, we did not observe any clinic delays.

Meeting people's individual needs

- Staff on the neonatal unit organised resuscitation training for parents who had children with complex health needs where the chances of resuscitation skills being required at some point were high.
- There were information leaflets available for children and young people which were targeting all ages for this service. The leaflets were only available in the English language.
- Staff told us they used and interpreter service to complete any translation for children and young people who did not speak English, or to help explain to the parents or carers about any treatment. The service also had the ability to book interpreters to attend the hospital for certain tasks. During our inspection, we saw the telephones available for the use of interpreter services.
- Staff told us about an incident where they had translated clinic appointment letters to a none English speaking child and family who continuously DNA for appointments. Once the letters were translated, the family attended all appointments.

Services for children and young people

- There were members of the nursing staff who were able use sign language to communicate with children and young people who had hearing difficulties.
- Staff in the radiology department had sourced paediatric gowns for use in their department. These were deemed more user friendly than a full sized hospital gown.
- A distraction box of items for children under the age of five was available in the radiology department to enable them to complete a procedure that the child needed, without causing too much distress to the child.
- There were display boards which had current safety information displayed for families, parents and children attending the children's outpatient department. It was noted however, the display board was quite high up the wall and not very visible to those who may wish to read the information.
- There were toilet facilities available in the children's outpatient department which were accessible for those with a physical disability.
- The hospital did not have their own learning disabilities nurse who specialised in paediatric patients; however, the children's ward did have access to the community learning disabilities nurse specialist if advice was required.
- Staff told us they were encouraged to use the 'about me' document for children with learning disabilities and complex needs if they were available. This prevented the repetition of questions about the specific care required for the child, but also enriched staffs knowledge on the individual care requirements for a child with learning disabilities and complex needs.
- Staff told us they were aware of specialist bereavement and palliative care teams within the hospital, however they did not have many children who required end of life care during admission as most children would be cared for in the community. Staff did tell us about a child who was considered as end of life care that they were able to provide them with the specialist input and also included chaplaincy services for the family.
- Mothers who were breast feeding infants admitted on the children's ward were offered a meal as well.
- Patient information leaflets were available for children and young people which were all evidence-based and within their review dates.
- The children's ward and neonatal unit had access to the hospital bereavement services for families that requiring this service. If they had a child who died during their admission, they would advise the families to use the service.
- Chaplains at the hospital held a yearly celebration of life for babies that had died whilst admitted. This provided parents with the opportunity to provide peer support to others and also seek further emotional support through the chaplaincy department if required.
- Since the last inspection, a child and adolescent mental health service (CAMHS) crisis response team were introduced who reviewed patients in the emergency department with a view to preventing admissions. If a child requires admission, the CAMHS professionals would review the child on the ward with a view to transferring them to an appropriate environment if required.

Learning from complaints and concerns

- There were two formal complaints made about the service between January and September 2016. In the neonatal ward, there was a notice, which provided staff with information about where in the investigation process they currently were. This information was anonymised to protect the confidentiality of the complainant. No learning point had been identified at that time, but full review of the complaint with staff was expected at the conclusion of the complaints.
- Staff working in the children's outpatient department was only aware of verbal complaints made against the department. They told us they would try to resolve any complaints locally before referring to the hospital patient advice liaison service (PALS) team.
- Information was displayed in the ward areas, which provided details of how to complain.
- The patient advice and liaison service (PALS) had 10 entries recorded for this hospital in regards to children and young people. Nine of these were complaints, which were now closed; one was a contact from a parent who was arranging a support group for other parents using the service.
- Children and relatives who we spoke with told us they knew how to make a complaint if they felt they needed to.
- The electronic system being piloted by children and young people for providing feedback also had the ability to provide more formal feedback for the service.

Services for children and young people

Are services for children and young people well-led?

Good

We rated well-led as good because:

- The risk management for the service was comprehensive and was seen as gold standard within the trust.
- There was clear flow of information about governance, risk management and quality performance from trust board to ward, and vice versa.
- Staff told us local managers were visible and approachable and made them feel appreciated.
- There were opportunities for members of the public to provide feedback about the services.

Vision and strategy for this service

- All staff told us they were concerned about the future of children and young people's services at the hospital and felt there could be more involvement and flow of information from the head of service about any potential changes due to the impact this will have.
- The trust had a five year plan which contained plans for children and young people's services. The plan recognises current ways of working were not sustainable and was currently in a consultation period over the future of children's services at the hospital.
- The trust vision and values were displayed in the children's ward and neonatal unit, and staff were aware of these.

Governance, risk management and quality measurement

- Children's service was in the Women's and Children's business group. Quality governance structures were identified within this structure. The organisational diagrams for governance showed a comprehensive governance system in place, which identified the lead persons for each area.
- Monthly governance meetings were conducted which had attendance from all members of the multidisciplinary team.
- There were quarterly governance meetings, which were pan-trust and involved all key personnel from the service.
- There were clear lines of communication for governance, risk management and quality measurement, which cascaded information from the board level to ward level, and vice versa.
- Each area had its own local risk register. Risks classified as 15 or above would be added to the business unit risk register, and risks of 20 or above were added to the trust risk register. The biggest risk on the risk register was around recruitment of clinical staff, mainly nursing. There was evidence of regular review of the risk register and proactive addition of new risks when identified.
- All staff told us the largest worry was in relation to both medical and nursing staffing. This reflected the largest risk on the risk register. There had been mitigating actions implemented as to how this could be managed, and we saw evidence of minutes where the actions had been approved which included an uplift of band four nursery nurses due to the inability to recruit band five registered children's nurses.
- There was a neonatal risk manager for the service. They were responsible for the management of the risk register, reviewing incidents and looking at themes and trends of risk and incidents within the service. As there was no risk manager for paediatrics, the lead for neonates provided support to them.
- Staff regularly attended ward meetings where important information about the service, including incident feedback, complaints feedback and information about staffing and risks was cascaded down to them.
- The lead for the service also produced a newsletter on significant issues that they wished staff to be aware of. We saw evidence of these newsletters in the children's ward and neonatal unit and staff told us they found them useful for keeping up-to-date with important issues.
- Local safety standards for invasive procedures (LocSSIPs) were produced for the children's services to provide safer care and reduce patient safety incidents. These reflected the details contained within the national safety standards for invasive procedures (NatSSIPs) where it was advised local safety standards are produced for procedures which could result in a never event. An example of a LocSSIP produced by the hospital was for the placement of nasogastric tubes (tubes placed through the nose down to the stomach) on neonatal patients.

Leadership of service

- Staff told us they had visits from the executive team, although this did not happen very often.
- There was a non-executive director (NED) who represented the children and young people's services at board level meetings. Senior staff told us they engaged with the NED and they had visited the children's ward area.
- Staff told us the matron is for both neonatal services and the children's services were visible and approachable and they would feel confident going to them if they had concerns. Staff told us they felt appreciated by the matrons for the standards produced despite being under pressure at times. One member of staff told us the nurse in charge had thanked them for their hard work after each shift. This made them feel appreciated.
- Ward managers of the children's ward and neonatal unit had an open door policy for staff and all staff told us they felt comfortable approaching them if they had concerns or difficulties.
- All staff were aware of who the service lead was, although not all staff told us they were visible. Some staff acknowledged that as they worked shifts, it is possible they visit when they were off shift. The service lead has however been instrumental in the developments for the service.
- A nurse in charge is identified for each shift on the children's ward and neonatal unit. Staff would approach these individuals first with any concerns or advice was required. The nurse in charge was usually the most experienced nurse on shift, however to develop junior staff, they may be in charge with the support of an experienced member of staff. Ward managers were available Monday to Friday for escalation of any issues, which the nurse in charge could not overcome.
- All consultants had up-to-date job plans for their roles. Staff told us they were imminently going to implement electronic job plans once some final refinements had been made.
- There was a leadership course which members of staff in a position to develop their leadership further were encouraged to attend.

Culture within the service

- Duty of candour training had taken place at the hospital, which 12 members of staff had completed. All staff spoken with had an awareness of the requirement for being open and honest.
- All staff spoken with told us they felt supported by their local managers and matrons, and that there was a very positive culture within the service. This was despite some areas experiencing staffing challenges.
- All staff spoke about how their main focus was providing excellent care to the children and young people who used the service. This was the one thing they were all proud of and passionate about.
- Despite most staff telling us they were concerned about the future of paediatric services at the hospital, morale was good and staff enjoyed working at the hospital.

Public engagement

- There was a support group run by parents of infants that were admitted on the neonatal unit called little snaps. This provided support and social functions/gatherings for parents to meet and discuss on-going issues. The hospital would occasionally use this group for gathering views on any potential developments for the service.
- Staff from the neonatal unit told us of a group of parents of infants cared for at the unit who were campaigning against the prospect of the neonatal unit closing. We saw evidence of the work that had been done as part of their campaign, which was displayed in the unit.
- Children and their parents engaged with the implementation of a new menu. A questionnaire was given out asking what they would prefer, after collating all the responses; the new menu was trialled before full implementation.
- The children's service had a twitter page to voice their comments (tweet) about the service. This was real time information and staff were able to view and respond (tweet) back to the individual.
- Comments cards were given out in the neonatal unit to parents and carers. We saw evidence of actions being taken because of the comments made. This included additional baby change facilities in the parent's sitting room and mirrors provided in the parents accommodation.

Staff engagement

- Staff within the service were nominated for trust awards to acknowledge their engagement with the service.
- The matron for children's services was in the process of gaining staff feedback through a satisfaction survey. We saw evidence of staff responding to this survey.

Innovation, improvement and sustainability

- The training lead for medical trainees in neonates and paediatrics had received recognition for the work they had done to improve the training programme. Feedback from previous trainees was also reviewed and showed appreciation for the support during their training position.

Outpatients and diagnostic imaging

Safe	Inadequate
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Inadequate
Overall	Inadequate

Information about the service

Boston Pilgrim Hospital is one of seven main sites delivering outpatient services across Lincolnshire to a population in excess of 720,000. The trust provided 677,328 outpatient appointments (including new and follow-ups) between March 2015 and February 2016. Of the 677,328 appointments 296,673 occurred at Pilgrim Hospital. The hospital also provides a full range of diagnostic imaging, including general radiography, computerised tomography (CT), ultrasound, magnetic resonance imaging (MRI), nuclear medicine, breast screening and symptomatic breast imaging and interventional radiology at Pilgrim Hospital.

The clinical support business unit managed outpatient and diagnostic imaging services. The business unit was responsible for the delivery and nursing staffing of the majority of clinics, including administrative functions. Other business units across the trust were responsible for the performance and management of the different clinic specialties.

Outpatient services provided at Pilgrim Hospital included ear nose and throat (ENT), ophthalmology, dermatology, cardiology, physiotherapy, occupational therapy and urology. The most used outpatient specialties were ophthalmology, and cardiology. Most outpatient activity was conducted in the main outpatient department, which is a multi-speciality unit. Consultants or specialist nurses run clinics provided in this department. There were some independently run specialist outpatient areas including the royle eye department, physiotherapy and the Boston breast unit.

For diagnostic imaging, we visited the radiology department, dental x-ray, nuclear medicine department, breast-screening unit, CT, MRI, interventional and fluoroscopy rooms. We spoke with 17 staff including radiographers, sonographers, clinical imaging assistants, radiologists, clinical technologists, clerical staff, support managers and radiology managers. We checked five resuscitation trolleys and emergency equipment. We spoke to three patients.

For outpatient services we visited the royle eye department, main outpatients, cardiology, ENT, Boston breast unit, physiotherapy, occupational therapy, dermatology, ophthalmology, fracture clinic and health records. We spoke to 64 members of staff including secretaries, receptionists, doctors, nurses, students, physiotherapist, occupational therapists, managers, and health care support workers. We also spoke to one volunteer. We looked at seven items of equipment including three resuscitation trolleys. We reviewed seven patient records and a further 15 records to assess the quality of patient records. We spoke to eight patients and their relatives.

Outpatients and diagnostic imaging

Summary of findings

We rated this service as inadequate because:

- Outpatient services did not manage and maintain medical records in a way, which enabled the safe care and treatment of patients, complied with information governance requirements, or ensured patient confidentiality. This included the availability, the condition and storage of medical records.
- There were delays to patients accessing treatment and care in all areas of the patient pathway. Data showed continuous poor performance against national cancer targets. We saw significant numbers of patients overdue for appointments including new and follow up appointments. In some cases, the 2016 position was worse than the previous year. The trust performance against referral to treatment times had declined between June 2016 and September 2016.
- Data showed 8,108 incomplete patient appointment outcomes, which staff did not record on the electronic record system. Data supplied by the trust showed the current position was worse than the previous year.
- There had been significant delays in the reporting of diagnostic imaging results due to technical difficulties. This affected patients receiving timely access to care and treatment.
- Not all staff reported incidents in line with trust policy. Therefore, not reporting incidents presented a risk to patients because it meant departments could not put mitigating in place to prevent an incident from happening again.
- There were delays in staff typing and sending clinic letters to GPs and patients. We saw significant numbers of letters waiting to be typed.
- Not all staff received appraisals in a timely manner. Some staff we spoke with said their appraisals were not meaningful and did not provide opportunities to develop. In particular, administrative staff did not benefit from regular or meaningful appraisals.
- Progress against some poor performance and identified risks was slow. We saw issues identified since our last inspection had not been address for example, overbooking of clinics. Reports showed there had been long standing issues for example, condition of health records, which the trust had not addressed.
- We had concerns in relation to the culture in some outpatient departments. Some staff said they had experience bullying and intimidating behaviour particularly from managers. The majority of administrative staff we spoke with said managers did not support or listen to them. There were shortages in administrative staffing.

However we also found:

- Staff delivered patient care in line with evidenced based care and best practice guidelines. Staff had access to relevant trust policies and national guidelines to support them deliver patient care. Staff reported incidents in line with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R
- There was effective multidisciplinary working with staff, teams and services working together to deliver care and treatment to meet the patient's needs. Staff from different specialties and roles provided one-stop clinics in some departments.
- Staff were caring, compassionate and involved patients in their care and treatment. We saw positive interactions between staff. Patients were positive about their care and treatment. Staff supported patients in the event of bad news.
- Services met the needs of local people with some specialist services available for patients. Some clinics developed new ways of working to meet demand and address overdue appointments for example virtual clinics.
- Staff had access to translation and interpretation services and where possible used their resources to enhance the patient's care pathway.
- We saw some examples of patient and staff involvement. We saw where changes had occurred because of patient and staff involvement.
- We saw examples of departments innovating to improve care for patients.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Inadequate

We rated safe as inadequate because:

- The poor condition of and unavailability of health records was having a negative impact on all clinic areas, resulting in appointment delays, additional anxieties and work for clinic staff and causing difficulties and delays in medical information being located.
- The hospital did not secure records in a way, which protected patient confidentiality. We saw numerous occasions where staff left confidential records in public areas. The environment was hazardous for administrative staff in areas where boxes of medical records had been inappropriately stored.
- As of the week of our inspection, there were 8,108 incomplete patient appointment outcomes, not recorded on the electronic record system. Data supplied by the trust showed the current position was worse than the previous year. This presented a risk to patients in their ongoing treatment and care.
- Data from the trust showed 18,636 patients had been missing on the electronic patient administration system. Of these, 1,119 patients required a further appointment meaning they had been missing from the waiting list. There was an ongoing process to continue to identify further patients missing from waiting lists. This presented a risk to patients' ongoing treatment and care.
- Not all staff reported incidents in accordance with the trust policy. We saw an example of the radiology department not acting on learning from incidents.
- Cleaning audits showed standards of cleanliness in a number of high-risk areas were not up to trust standard. Staff did not document ultrasound probe cleaning.
- The trust had no procedures to test and replace emergency buzzers in clinic rooms. Therefore, there was no guarantee they would work in the event of an emergency or seriously unwell patient.
- Staff in the royle eye department had not checked fridge temperatures on fridges storing medication on a daily basis in accordance with trust policy. In addition, staff did not escalate recorded temperatures out of normal range, in line with trust policy.
- Shortages of administrative staffing had an impact in delayed typing of clinic letters and records management.

However, we also found:

- Staff reported incidents in line with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R)
- Staff observed trust policies on hand hygiene and bare below the elbows. Staff wore appropriate personal protective equipment (PPE) when delivering care and treatment.
- Outpatient and diagnostic imaging departments had processes in place to manage deteriorating patients including admitting them to wards.
- The trust had a radiation protection service including a radiation protection advisor, a medical physics expert, a radiation waste advisor and radiation protection supervisors. This met IR(ME)R and Ionising Radiation Regulations 1999 requirements.

Incidents

- Outpatient and diagnostic imaging department reported 369incidents for the period July 2015 and June 2016 at Pilgrim Hospital. Of the 369 incidents, the trust reported two as causing severe harm, 13 as moderate harm, 38 as low harm and 316 reported as no harm. The most common incidents reported were regarding appointment issues including patients not receiving appointments, overbooking and patients not attending appointments. Medication errors (51) and patient records not being available for clinic (52) were the other two highest numbers of reported incidents.
- In accordance with the serious incident framework 2015, the outpatients and diagnostic services directorate reported no serious incidents (SI) which met the reporting criteria set by NHS England during August 2015 and July 2016.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and

should have been implemented by all healthcare providers. Between August 2015 and July 2016, the trust reported no incidents classified as never events for outpatients and diagnostic imaging.

- The trust used an electronic reporting system to record and report incidents. All staff we spoke with knew how to report incidents. Staff we spoke with described the incident reporting system and felt comfortable using it. They gave us examples of reported incidents for example patient falls.
- Some staff did not use the reporting system for missing patient records or complications of procedures and instead documented them in the patient notes. In cardiology, the department did not keep a log of those complications. Staff said it took too long to fill in an incident form and staff in other departments said nothing changed when they reported incidents. Therefore, they did report incidents. This meant some departments could not properly assess risks to patients and investigate when things went wrong.
- Nursing staff discussed feedback and learning from incidents at daily huddles and at team meetings. For example, we saw from minutes of the royle eye department team meeting (October 2016) a discussion on unknown persons wandering around the department. In response to this staff locked the nurse's office when unattended and a keypad lock on the doctor's office. We saw discussion in the main outpatient's team meeting (October 2016) changes in practice regarding the confidentiality of notes and electronic information. The team introduced privacy screens to protect patient confidentiality.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.' We saw from incident investigations incident investigators had involved patients and their families through the investigation process.
- Some staff were not familiar with the term 'duty of candour' but applied the principles regardless of the severity of the incident. Information from the trust showed staff apologising and explaining what had happened to patients once staff knew about an incident or an error. Staff gave examples where they had been open and transparent such as diagnostic scanning errors and incorrect diagnosis.

Incidents – Diagnostic Imaging

- NHS trusts are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). Diagnostic imaging services had procedures to report incidents to the correct organisations, including CQC
- Every radiographer we spoke to knew how to report incidents. There had been six radiation incidents reported to CQC over the 12 months preceding the inspection. The trust had investigated all of these incidents and had put measures in place to reduce the likelihood of similar events happening in future.
- As of 28 September 2016, staff reported 77 incidents through the trust incident reporting system relating to the imaging department. Many of these related to the image-reporting backlog. Following investigation there had been no reports of harm to a patient relating to a delay in reporting of their images.
- Staff told us managers shared feedback and learning from incident investigations during staff meetings and through newsletters. The medical exposures committee discussed incidents but feedback from the committee did not always get back to staff.
- Local rules were seen as required under Ionising Radiations Regulations 1999 (IRR99) and were within review dates. IRR99 are a statutory instrument, which form the main legal requirements for the use and control of ionising radiation in the United Kingdom. Local Rules within nuclear medicine were currently under review
- Staff informed us of a serious incident in which the radiology department was involved. The incident occurred at Lincoln Hospital and managers shared learning across the trust. In this case, staff had incorrectly labelled (a marker) the right and left side of the x-ray. Staff used x-rays to diagnose further treatment, which they carried out on the patient on the wrong side of the chest before they identified a mistake. The department at Pilgrim Hospital had not re-audited marker use and had therefore not acted on the learning
- Every radiographer we spoke to knew what 'duty of candour' was and all said they would be open and honest with a patient if something had gone wrong. We saw screen-savers displayed on computer screens as a reminder to staff about duty of candour.

- Radiologists conducted a discrepancy audit in May 2016. The audit found seven discrepancies. All errors were communicated to referrers and patients under the duty of candour and in all cases it was deemed there had been a delay to diagnosis but no harm to the patient

Cleanliness, infection control and hygiene

- All wards and departments were required to undertake monthly hand hygiene audits, using the world health organisation (WHO) five moments of hand hygiene tool. Between January 2016 and June 2016, the audits showed outpatient departments had an average of 99% compliance with trust hand-hygiene policies. We saw staff discussed cleanliness audits at their team meetings.
- Staff completed cleanliness audits for clinic environments and equipment. Data from the trust for the period May 2016 to October 2016 showed cleaning of the seven high risk areas including main outpatients, fracture clinics and the royle eye department fell below the trust standard of 95%. The lowest average cleanliness score for this period was the fracture clinic averaging 83%. Urology (93%), main outpatients (91%) and the royle eye department (91%) were the best performing areas just below the trust standard.
- Areas of lower risk had to meet the trust target of 85% for cleanliness. These areas included the breast unit, dermatology and ENT. All areas had met the trust standard for the period May 2016 to October 2016.
- Where audits identified poor areas of practice or cleanliness, we saw staff implemented actions to address areas of concern. We saw from action logs staff had signed and dated them to state when staff had completed mitigating actions.
- We observed all staff were bare below the elbow, in keeping with trust policy to help prevent the spread of infection.
- We saw items of equipment had 'I am clean' stickers when staff had cleaned them. We saw staff wiping down equipment after use and before the next patient arrived into the clinic.
- The environment was visibly clean. Staff cleaned departments daily and a domestic supervisor undertook weekly cleaning checks. We saw records of completed checks and cleaning logbooks completed by staff.
- Hand gel was available at the entrance to clinics and waiting area. We observed staff using the gel to clean their hands in accordance with trust policy.

Cleanliness, infection control and hygiene – Diagnostic Imaging

- Services had procedures to inform staff how to handle known patients who had infections. Staff ensured patients were imaged either first or last on the day list to ensure rooms could be cleaned therefore minimising risk of cross contamination
- We saw hand hygiene audits showed 100% compliance in July, August, and September 2016.
- In nuclear medicine and interventional radiology we saw a cleaning schedule with associated signatures
- In nuclear medicine the department was visibly clean and tidy
- Staff said they cleaned ultrasound probes after intimate examinations, in line with manufacturer recommendations, but there was no documentation to support this. Therefore, there was no documented evidence of probe cleaning.
- Staff changed curtains to changing facilities every three months but if they became soiled staff changed them immediately. This was in line with trust policy.

Environment and equipment

- Staff stored patient records in corridors and in offices. We saw boxes of records stacked up three or four boxes high in a corridor. We visited five medical secretary offices and saw they had boxes of records stacked up next to desks and along the floor. This presented a risk of injury to staff in terms of a tripping hazard and staff having to pick heavy boxes up to move them. One member of staff told us they had injured their wrist picking up heavy patient records. Staff said they had reported the issue of records as an incident however, nothing had happened.
- A member of staff gave an example of sustaining a hand injury from a nurse moving a bed through a corridor narrowed by trolleys storing patient records along the wall. The trust said this incident was reported immediately at the time of injury with more space found to store the trolleys. The trust said a longer term solution would be in place by March 2017.
- The clinical engineering department were responsible for the checking and maintenance of equipment. A statement from the trust said the clinical engineering

department regularly monitored what equipment needed replacing or maintaining. Staff said they had no concerns regarding equipment. Staff put any issues with equipment on the risk register especially when approaching the end of its useful life.

- We saw the storage of some clinical equipment including hypodermic needles in cardiology were not secure. We found the storeroom was unlocked and therefore publically accessible.
- We saw training certificates and risk assessments for staff using laryngoscopes (instrument for examining the larynx, or for inserting a tube through it) in ENT clinics. Staff knew procedures for using the instruments as well as the guidelines on cleaning them after use.
- The ophthalmology injection room was in the maxillofacial department. There was a small waiting area and a nurse procedure room. The room had a non-particulate ceiling (to avoid dust) in accordance with guidelines from the Royal College of Ophthalmologists (RCO).
- Some clinics had buzzers used to alert other member of staff in the event of an emergency. However, staff said they did not regularly check or maintain the buzzers. Staff could not tell us about any maintenance programme for buzzers. This was a particular risk in clinics such as cardiology where staff tested patients for heart conditions using gym equipment for example, treadmills. The replacement and testing of emergency buzzers was not included in trust policy for managing medical devices or their medical equipment maintenance assurance document.
- Five administrative staff we spoke with said they did not have proper screen breaks during the day. All five said managers told them talking to the person next to them constituted a screen break or going to make a cup of tea. However, all staff said managers only allowed them to make a drink and bring it back to their desks, which took less than five minutes. Administrative staff said they had previously escalated this to managers. Health and Safety (Display Screen Equipment) Regulations 1992, Regulation 4, is concerned with the daily activities of users and states: "Every employer shall so plan the activities of users at work in his undertaking that their daily work on display screen equipment is periodically interrupted by such breaks or changes of activity as reduce their workload at that equipment." Following our inspection the trust told us staff received training around their responsibilities regarding screen breaks and staff could take screen breaks if required.
- Some parts of the outpatient environment caused challenges in maintaining patient confidentiality. For example we saw nurses stations, equipped with computers containing patient information in corridors near waiting areas. This presented a risk of patient's personal information being visible to other patients. Staff and senior nurses knew about this risk and had trialled several ways to mitigate risks. Staff told us they had recently ordered partitions to help maintain confidentiality and keep computers hidden.

Environment and equipment – Diagnostic Imaging

- Imaging equipment had regular servicing carried out by manufacturer engineers. We saw evidence of the manufacturers completed service reports. We also saw evidence of routine surveys of some imaging equipment.
- Equipment was clean and staff used green stickers to show when equipment was clean.
- We saw up to date quality assurance (QA) records for some imaging equipment within the trust. The QA records highlighted to staff when measurements were not as they should be.
- Staff told us the trust had recently introduced a QA programme had for all ultrasound probes in the trust. Ultrasound probes are easily damaged which may affect image quality, therefore regular QA may reduce the likelihood of a poor quality examination.
- In nuclear medicine we evidenced records of calibration and quality assurance of equipment and syringe guards were always used for drawing up of radioisotopes
- All QA records in the dental department for imaging equipment were up to date
- Staff appropriately disposed and recorded disposal of all waste from the nuclear medicine department.
- We saw nuclear medicine had Environment Agency certificates and permits for sealed sources. A sealed radioactive source is radioactive material permanently sealed in a capsule or bonded and in a solid form. The design of the capsule of a sealed radioactive source was to prevent the escape of radioactive material during normal usage and under probable accident conditions.

- Staff used personal protective equipment (PPE) such as lead gowns. Lead gowns acted as a radiation shield while staff performed imaging procedures. Staff cleaned the gowns every morning.
- Staff checked the resuscitation trolleys and emergency equipment in CT, MRI, interventional radiology, breast imaging and nuclear medicine daily and weekly in line with trust policy. All records were complete and up to date. There was a paediatric resus trolley in the interventional room which was evidenced as being checked regularly
- In nuclear medicine there was a separate 'hot' toilet facility for patients who had been injected with a radioisotope
- Staff locked dirty utility rooms using keypad access and oxygen supplies were securely stored.
- Staff undertook weekly stock rotation of equipment including catheters, wires and balloons.
- Ward patients had their own waiting area with three bays, oxygen and suction but no call bells. This meant some patients could find it difficult to ask for assistance if left unattended.

Medicines

- Controlled drugs (CDs) are medicines requiring additional security. We saw CDs were stored and locked in fridges or cupboards. All medicines and CDs we checked were in date and we saw staff checked stock weekly for out of date medicines. We noted from records staff checked the majority of cupboards and fridges daily and the CD check records were complete.
- However, we saw staff did not check the fridge daily in the royle eye department and staff logged temperatures outside the expected range without escalation. We checked records from October and September 2016 and saw staff had not recorded temperatures for five days in October and nine days in September. Staff had recorded temperatures for the majority of this period as outside the expected range. Staff including senior nurses had not escalated this in line with trust policy therefore there was a risk to the safe storage of medicines in this fridge.
- We escalated this concern to a senior nurse in the royle eye department. The nurse checked the fridge who stated it was a possible issue with the thermometer but she would report it and get someone to come and look at it. On our unannounced inspection, we visited the department and the senior nurse told us they had not escalated the issue. They had not requested the maintenance department to visit and check the fridge. The senior nurse believed the problem had occurred due to staff leaving the fridge door open when retrieving medicines.
- Outpatient and diagnostic imaging services reported 51 medication errors between July 2015 and June 2016. The majority related to incorrect doses or incorrect information on the prescriptions received from pharmacy. Staff we spoke with said they would ring pharmacy directly and query any dosage information they had concerns about.
- Outpatient services had processes in place for the management of prescription pads (FP10). Clinics stored pads securely in locked rooms and cupboards. Clinical staff signed individual sheets out so there was an audit trail of who had used them and the FP10s were secure and in one place all the time. Staff logged the numbers of each prescription before sending them to pharmacy. We checked three sets of FP10s and saw staff followed these processes.

Medicines – Diagnostic Imaging

- Diagnostic services had patient group directives (PGDs) for all appropriate radiographers. These documents allowed radiographers to give patients contrast agents (a substance used to enhance the contrast of structures or fluids in the body during imaging examinations) and a limited number of drugs without an individual prescription from a doctor.
- Staff kept drug cupboards in nuclear medicine and interventional radiology securely locked and all drugs we checked were within date. Contrast media was in date and staff stored them in locked cupboards in the imaging department.

Records

- Between July 2015 and June 2016, outpatient services reported 52 incidents regarding patient records unavailable for clinics. We saw during our inspection numerous examples of notes being unavailable for the start of clinics. We observed at one clinic, there were 22 patient records missing at the start of clinic. All staff we spoke with said the availability of records was an issue. An audit of the ENT clinic conducted on 6 September 2016 showed 89% of records were available at the start of the clinic.
- The trust had a standard operating procedure (SOP) for when patient records were unavailable at clinics. The

SOP described procedures staff should undertake including attempts to locate the correct records and producing a spare set from information available so staff did not have to cancel the patient. Staff knew about this procedure and could acquire basic information to form a temporary set of notes.

- Staff from several clinics explained when they produced temporary notes they were not always than amalgamated, some staff believed a request had to be made for this to be done. Staff explained patients ended up with multiple sets of notes.
- The health records department had recently begun to audit the availability of records for the start of clinics. At the time of our inspection, the health records service had completed one specialty had started an audit of another. There was a planned timetable for audits however; because this audit work had just started, there was very little data on the overall availability of records for clinics.
- All staff we spoke with said the quality of some patient records was an issue. This affected staff being able to access appropriate information required to review care and treatment. We saw many examples of untidy notes not bound together and held together by elastic bands. We observed many more we did not try to open. Patient records were large and sometimes-in multiple batches for one patient. This meant staff could find it difficult accessing the correct or most up to date information on the patient. A recent report to the information governance committee highlighted there were some 300,000 records requiring repair, merging, volumising or destroying. This presented clinical risks of misdiagnosis or compromised patient assessment.
- Outpatient services did not keep records securely or in a manner that protected patient confidentiality. In the cardiology clinic waiting area, we saw seven boxes and two trays of confidential patient records and post (both incoming and outgoing) unattended. Letters were marked confidential however, patient's names and address details were clearly visible. We saw a patient test-referral form sat on top of mail and not in an envelope. The patient's personal details and information on tests received and required were visible. Patients were in the waiting room at the time. A member of staff said staff left patient records and mail in reception "all the time". We escalated this to managers who removed the post and said they would look at other solutions regarding the collection and delivery of mail.
- Confidential patient records were publically accessible in two different areas of the hospital. This included the health records department where the majority of patient records were stored and the orthopaedic secretaries' offices. Members of our inspection team walked through unlocked doors and in one area remained un-challenged by staff for ten minutes. This meant unauthorised persons could access what should be private and secure areas of the hospital and view confidential information. A medical secretary described an incident three years ago where a patient had accessed these areas. Staff said they had raised these issues with senior managers but they had made no progress. Following our inspection the trust told us they were examing options to rectify this issue at the time of our inspection.
- Staff stored patient records in corridors and in medical secretary offices. For example, we saw 130 boxes of orthopaedic patient records stored in corridors outside offices. This meant that patient records were not secure. In addition, it contributed to delays in locating patient records for clinics because when requested secretarial staff had to search for the correct records. Staff tracked patient records through an electronic tracking system but we saw examples where records were not where the system said they were. We saw a report to the trust health and safety committee highlighting ongoing problems within health records however; at the time of the inspection, we had not seen evidence of a response to this.
- Staff in the health records department prepared patient records for clinics the evening before or on the morning of clinics. Patient records were stored in locked trolleys. Staff left all the trolleys in the main outpatient's reception in the evening where they awaited collection for morning clinics. We observed the trolleys were still in main reception during clinic hours. Staff we spoke with said leaving the trolleys in the reception looked untidy and they were concerned regarding the risk of the public accessing these trolleys. We checked four out of eight trolleys with patient records inside. Staff had locked all

four trolleys however; we could open them with our hands without a key. Therefore, there was a risk members of the public could access private medical records if they wished to do so.
- Medical notes in cardiology were stored in an unlocked storeroom and in four large unlocked cabinets in the central corridor area of the department. This meant unauthorised persons could access the records.
- We reviewed eight patient records. We saw evidence of the consultation recorded in all sets of notes. Notes were legible, signed, and dated in line with general medical council (GMC) standards. All the sets we reviewed had previous clinic letters to GPs and contained referral information. Seven out of eight records were in chronological order meaning the most recent clinic appointment was at the front of the notes.
- Staff used stickers placed in patient records to identify a chaperone had been present in clinic. We saw six out of the eight we reviewed records had a sticker in them. Staff signed and dated the stickers. However, the sticker did not identify whether staff had offered the patient a chaperone and the patient declined. This was also not evident in the notes of the two records without chaperone stickers.

Records – Diagnostic Imaging

- The trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records are stored securely and access was password protected.
- Following an upgrade of the RIS and PACS on 16 September 2016 there was evidence of a developing backlog of reporting of images due to IT downtimes and unreliability of the systems.
- We saw evidence of a large backlog of unreported examinations within radiology, which led to long delays (in some cases of several months) to images receiving a radiology report. Staff we spoke with knew about these issues and the risks associated with it. We saw evidence radiology had systems to monitor the time taken to report each examination and ensure staff reported urgent and high-risk examinations as a priority. Radiology management said the trust had contracted two external reporting companies to assist with addressing the backlog. Therefore, risks to patients had been minimised.
- For radiology equipment used by non-radiology staff, such as the vascular and orthopaedic surgeons, we saw evidence that staff recorded patient radiation doses.

Safeguarding

- The trust set a mandatory target of 95% for completion of safeguarding training. Staff trained in both safeguarding children and adults. All staff we spoke with said they had completed safeguarding training. Compliance for safeguarding training as of 31st August 2016 for staff was 91% for diagnostic staff, 66% for outpatient management staff and 95% for therapy staff for safeguarding children. For medical staff 82% of diagnostic and 100% of therapy staff had achieved safeguarding children. All staff requiring level three safeguarding because children attended their clinics had received training. For example, ear nose and throat (ENT) and orthopaedics.
- For safeguarding adults 82% of diagnostic and 100% of medical staff had completed their training. For non-medical staff 91% of diagnostic, 62% of outpatient management staff and 95% of therapies staff had completed their training. Therefore, outpatient and diagnostic services met its target for therapies non-medical staff Safeguarding training but did not meet its target for diagnostics or outpatient management medical staff.
- Staff had safeguarding processes in place for children who did not attend clinics. Staff knew what the processes were and what to do if a child did not attend an appointment. All departments would send a letter on the first occasion and on the second contact, the appropriate authorities and agencies involved with the patients care.
- The trust had recently established safeguarding champions. The trust had provided staff with information about this and we saw it displayed throughout the departments on information boards.
- Staff knew how to access the trust safeguarding policy and all departments kept copies in folders accessible to staff. Staff knew their responsibilities in terms of safeguarding vulnerable adults and children. Some staff could give us examples of when they had used safeguarding processes to report incidents of domestic abuse. Staff who had reported safeguarding concerns

said they had been well supported by managers and senior nursing and medical staff. Staff said they could contact the trust safeguarding team directly in addition to speaking to a senior nurse.
- Radiographers knew who the safeguarding lead for radiology was and how to raise concerns. Staff received level three safeguarding training in the classroom and administrative staff were trained to level two.
- Female genital mutilation (FGM) is defined as the partial or total removal of the female external genitalia for non-medical reasons. The trust made information available to staff about FGM in their policy on domestic abuse.

Mandatory training

- Staff took part in an ongoing mandatory training programme. The trust delivered topics including fire safety, information governance, risk awareness, health and safety and basic life support. Some training was delivered yearly including fire safety and infection control. The trust delivered other training three yearly including health and safety, and risk awareness.
- The trust set a mandatory target of 95% for completion of mandatory training. The majority of staff we spoke with said they were up to date with their mandatory training however, some said the demands of their roles meant they struggled to attend. The trust met its target for therapies medical staff mandatory training for the majority of courses. The trust met its target for non-medical staff mandatory training for only some of the courses.
- None of the staff groups had achieved more than 50% compliance in basic life support (BLS) training. BLS training was included in the trusts yearly mandatory training.
- Mandatory training across imaging was 92% complete. The BLS figures brought the completion rate down as electronic records did not take into account whether staff had attended the intermediate (ILS) or advanced life support courses which negated the BLS from being required. Computerised tomography (CT) and interventional staff all undertook ILS training.

Assessing and responding to patient risk

- During the inspection we asked the trust for the current number of patient who had not had the outcome of their outpatient appointment recorded. As of the week of our inspection, there were 8,108 incomplete patient appointment outcomes, which staff did not record on the electronic record (e-outcome) system. This included patients from across the trust's outpatient services including those provided at Boston Pilgrim Hospital. The trust data included a breakdown of when the clinic appointments had taken place. The majority of the incorrect outcomes (6,689) were from appointments in October 2016. However, there were patients with incorrect outcomes from previous months dating back to June 2016 (45). Clinicians should complete the e-outcome form immediately after the clinic appointment in line with trust policy.
- Data supplied by the trust showed the current position was worse than the previous year. In October 2015, there were 6719 appointments with no outcome recorded. This was when staff was using a paper-based outcome collection method. When staff did not record the patient outcome, patients were at risk of staff not taking appropriate action regarding the care and treatment they needed.
- When staff did not record the outcome of appointments, patients were at risk of staff not taking appropriate regarding the care and treatment they needed. We spoke with managers within the medical business unit who explained they reviewed and took action against open electronic outcomes. Daily reports were available of patients who had attended the medical clinics and had not had their outcome recorded. Following our inspection the trust told us that they forcasted the numbers of incomplete outcomes would fall by half in early 2017.
- As part of the outpatient transformation programme to improve patients access and pathway through services the trust identified computerised records may not accurately reflect the number of patients who were actually waiting for treatment. Data supplied by the trust following the inspection identified there could be approximately 67,635 patients who had received initial treatment who may require a further medical review of their care but staff had not placed them on the waiting list.
- After the inspection the trust provided us with information showing validators had reviewed 18,636 (17,082 from external, 1,554 from internal) patients. Of these, 1,119 patients (985 external, 134 internal) required a follow up appointment and needed adding to the electronic waiting list. Out of the 18,636, there

were a further 2410 records queried by the external validation team and sent to the business units for further review. The trust said it was unclear how many records they needed to add to the waiting list.

- Validators had sent the 1,119 records already identified to be added to the waiting list so business units could appoint them and assess any clinical risk. The trust said patient waiting list figures for overdue patients by 6 weeks would increase because of this additional cohort. The trust did not know whether any patient harm had occurred through the follow up not having taken place when expected. Further reviews of an additional 9,000 patients were due to take place.
- There was a process in place across outpatient areas to manage deteriorating patients. If a patient became unwell, during their attendance, staff escalated to senior nurses and consultants were on hand to treat deteriorating patients immediately. Staff had access to resuscitation trolleys and could call for further urgent assistance. Staff could move patients to the emergency department for emergency intervention.
- Outpatient departments had processes in place to admit some clinically unwell patients onto wards. Staff escalated the requirement to admit patients via the site or bed manager. In cardiology, staff referred patients to the on call cardiology consultant who in turn would admit patients through the emergency department, coronary care or the medical assessment unit.
- Most clinic rooms had buzzers, especially in clinic areas where patients were more at risk of becoming ill. Staff used buzzers to alert other members of staff there was an emergency in their clinic room. Staff we spoke with all said if they heard a buzzer they would immediately respond.
- Outpatient services recognised, assessed and managed risks associated with bowel cancer. Staff assessed urgent referrals for their suitability to receive a telephone call from the specialist nurse rather than having to wait for up to two weeks to come into the outpatient clinic. Following a telephone consultation and assessment, patients who needed further urgent investigation were booked in for their tests. This enabled a diagnosis to be made sooner and where necessary treatment to be commenced.
- The ophthalmology department mitigated risk to patients by performing visual acuity tests on all patients before and after their appointments. This was to check patient's vision had not been affected post appointment.
- Patient health records contained a designated front sheet to aid in the identification of any known risk. For example, the sheet contained space to put information about a current or previous infection, allergies or previous anaesthetic reactions.
- Urgent referrals for example those where cancer was suspected were identified by the referring GP as requiring an appointment within two weeks of the referral. Staff gave these appointments highest priority when clinics slots were available and allocated.
- Each patient had their own curtained bay both pre and post interventional radiology procedures. This provided them with privacy but allowed staff to monitor their condition in case they deteriorated

Assessing and responding to patient risk – Diagnostic Imaging

- An 'in-house' radiation protection service supported the trust service as part of the ongoing work around patient safety. They provided the radiation protection advisor (RPA), radiation waste advisor (RWA), medical physics expert (MPE), for diagnostic imaging, nuclear medicine, and provided support for lasers and magnet use within diagnostics throughout the trust.
- The service had radiation protection supervisors (RPS) for each controlled radiation area. Their role met the Ionising Radiation Regulations 1999.
- We reviewed the radiology risk register. It included the IT issues related to the installation of the regional PACS. The installation of the PACS had caused risks to patients because it caused delays to reporting and in turn affected the timeliness of patients accessing further treatment. We saw the trust had mitigated risks to patients.
- All radiographers we spoke to knew how to escalate significant or unexpected findings. The duty radiologist was available to hot report (immediate report) any of these significant findings. Staff told us there was a policy for escalating significant findings to referrers quickly.
- We saw staff used a skin dose policy in interventional radiology. This helped staff provide guidance and information for patients on the side effects of radiation to the skin helping them to minimise any risks of side

effects. These were evidence based however, it appeared the service had not reviewed them since 2010. The policy was still based on the latest information meaning there was no immediate risk to patients.
- Radiology staff used The Society and College of Radiographers safety checklist was for the purpose of "pause and check" before all imaging examinations.
- We saw exposure charts for diagnostic procedures displayed in x-ray rooms including paediatric values.
- Staff reported ultrasound scans in a central hub so staff could get urgent advice from colleagues where necessary. Staff reported on all images at the time of examination to minimise risks of delays to patients.
- Imaging services prioritised urgent imaging reporting including scans on cancer patients. This helped to minimise risk of delays to urgent treatment they required.
- The ED had a ceiling mounted X-ray tube in the resuscitation department to ensure rapid imaging for emergency patients.

Nursing staffing

- Outpatient departments at Pilgrim Hospital employed 79.99 whole time equivalents (WTE) of nursing and non-nursing staff.
- Data from the trust showed there was a combined 5.11 vacancies (1.83 wte nursing and 3.28 wte health care support worker)For June 2016, the total number of planned whole time equivalent registered staff (WTE) to work in outpatient departments was 280.09 WTE. The actual numbers of registered staff who worked in June 2016 was 176.95 WTE. The planned number of WTE non-registered staff was 196.13 for the same period. The actual number of WTE non-registered staff working over this period was 123.17.
- The reasons for the shortfall were vacancies and sickness. Nursing staff had a vacancy rate of 2.52% and the average turnover rate was 14.75% based on six WTE staff leaving. Outpatient services had a sickness rate was 4.87%.
- To fill gaps in staffing levels outpatient services used bank and agency staff. From April 2015 and March 2016, outpatient services had a bank usage rate of 7.35%. The trust informed us that agency staff had not been used with outpatient departments during 2016.
- There are no specific national guidelines to determine staffing levels and skill mix within outpatient areas. Managers and senior nurses determined staffing levels by type of workload and department need. For example, there were nursing requirements to assist in minor surgery, or other procedures. Some required specific qualifications such as orthopaedic practitioners and some required staff to undertake chaperoning duties.
- Outpatient services based staffing establishments on historical figures and trends. In some areas, staffing levels had increased in line with demand. If shortfalls occurred then staff escalated via the clinic co-ordinator to senior nurses. The matron or sister would decide on staffing moves to support safer staffing levels throughout the department. The trust said work continued to review the staffing needs for outpatient departments.

Staff had daily handovers called huddles. Staff had huddles twice a day, once in the morning and

once in the afternoon for part-time staff arriving on shift. Senior nurses conducted huddles and discussion included staffing levels, which consultants were running clinics and any patients requiring special assistance.

- The outpatient service provided new staff, including bank and agency, with an induction checklist. The checklist included familiarisation with the environment, key members of staff, understanding equipment and daily checks including resuscitation trolleys. The induction checklist included personal development and competencies to do certain procedures or use certain equipment for example, blood glucose machine training. We spoke to three new members of staff all of whom said their induction was robust and helped them settle into their environment. We saw one example of a completed induction checklist.

Medical staffing

- Pilgrim Hospital did not report a vacancy rate for outpatient services for medical staffing. The relevant business units provided medical staff for clinics. Medical consultants and registrars worked in outpatient clinics on a rota and often across several sites. At the time of our inspection, there were gaps in consultant staffing which made some clinics busy and with long waiting times. We saw there were vacancies in some specialties in particular cardiology, vascular and ophthalmology. There was an ongoing recruitment campaign to recruit more consultants.

- Between April 2015 and March 2016, the average turnover rate was 20.71% in the outpatients department. The service based the rate on 13 WTE staff leaving. The trust reported an average sickness rate for the latest financial year as 0.60% and the total number of WTE days lost was 267.20.
- The trust employed locum doctors to cover clinics at Pilgrim Hospital as required for staff holidays or other leave.

Administrative Staffing

- Administrative departments had shortages in staffing and staff said, "We do what we can". At the time of inspection the health records department had 7.95 FTE vancancies against an establishment of 22.72 FTE staff including staff on maternity leave and one on long term sick. At the time of inspection the service used 5 FTE of agency staff cover and provided some bank cover.
- Data from the trust showed administrative staffing absence rates of 8.29% for health records staff and 3.66% for reception staff. The average for Pilgrim Hospital was 6%.
- Staff described how they were under pressure and required more staff because they could not meet demand or trust processes for clinic preparation.We saw in health records one member of staff allocated to find all the patient records for the next day's clinic. Some secretarial staff were behind in typing clinic letters for patients who had attended clinics meaning there were delays in patients and GPs receiving important information.
- Staff working at the main outpatient reception desk also had responsibility for managing and booking follow up appointments (including filling gaps in appointment slots) when required. The trust had procedures for staff undertaking these functions. Staff said it was hard to concentrate on both roles and we saw the reception was a busy area with a constant stream of patients. This was particularly difficult to manage when there was a shortage of staff. The trust responded by saying staff were meant to undertake additional tasks during quieter periods.
- stream of patients. This was particularly difficult to manage when there was a shortage of staff.
- Managers told us as part of the ongoing outpatient transformation programme they were considering administrative staffing levels. However, the team needed to finalise the business case prior to an organisational decision. This meant there was a risk back office services would continue to face ongoing challenges to meet demand
- Administrative staff told us managers did not produce rotas until the Monday of each working week. This meant staff did not know where they would be working in advance and therefore could not prepare for that day. For example, staff dressed according to where they worked because temperatures and conditions varied across the department. Staff said this was because managers did not trust them. Managers confirmed they released rotas to staff at the beginning of each week but the reason was to be more responsive to actual staffing levels due to staff vacancies.

Diagnostic Imaging staffing

- Pilgrim Hospital had a radiologist on call for any examinations that required a radiologist to be on- site. The trust outsourced out of hours cover for all other radiology examinations to an external company (6pm to 9am, Monday to Sunday). There was one radiologist per site at the weekend.
- At the time of the inspection, there were nine radiologist posts vacant out of 26 WTE funded establishment. Managers said recruiting radiologists to the area was an on-going challenge. They said due to the difficulty in recruiting radiologists, they had to look at alternative arrangements for ensuring service was maintained. These arrangements included employing a radiologist from overseas who worked at the trust three weeks out of every four and sourcing specialist radiologist services, for example paediatric reporting, from nearby trusts.
- The hospital had two radiology registrars working in the radiology department.
- Diagnostic services had several radiographer vacancies, half of which were band six roles. The department had recently advertised four band six radiographer posts. However, radiology management told us they were likely to fill the posts using internal candidates. This meant there would be more band five vacancies. Managers filled the vacancies with locum staff.
- Following a recruitment drive from Portugal, the trust offered positions to two locum assistant practitioners. The locum practitioners entered the trust at band four positions and promoted to band five when their

professional registration was finalised. The locum practitioners told us they had received good training and induction and felt well supported within the department.

- Imaging services had one radiographer on call overnight with an additional computerised tomography (CT) radiographer on call from home.
- One radiographer said they felt vulnerable when lone working out of hours, because patients were not often escorted by members of staff. Lone workers had to sign in with the security department and staff had a call alarm procedure in case of emergency.
- Radiographers told us there was no incentive for staff to stay at Boston due to lack of progression and staff moved to other hospitals for other opportunities. However, at the time of the inspection radiology management told us of several training opportunities for radiographers, ultrasonographers and mammography staff.
- Managers were looking at how to attract staff to Boston. They looked to include more cross-site working in their long-term plans including ultrasound and mammograms. In the interim, staff worked across Lincoln and Boston hospitals as short-term cover for absences.

Major incident awareness and training

- In the event of a major incident, the trust had a major incident plan to guide staff of all levels, and in all locations, as to what actions they needed to take. This included establishing the outpatient services managers could cancel to accommodate casualties.
- The majority of staff we spoke with knew where to find it for example, on the trust intranet or in a folder in the department. Senior nursing and medical staff knew about the impacts to their services in the event of a major incident. For example the majority of clinics would stop, staff redeployed to support the emergency department, wards or clinics required to support large numbers of casualties such as the fracture clinic.
- Fire safety training was part of the trusts mandatory training. The royle eye department displayed a fire evacuation plan. This helped patients and staff know where to go in the event of a fire.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not rate effective however we found:

- Staff delivered patient care in line with evidenced based care and best practice guidelines. Staff had access to relevant trust policies and national guidelines to support them deliver patient care.
- Staff in diagnostic imaging conducted regular audits to inform the way they delivered in treatment and care in line with regulatory requirements. The audit results were positive.
- There was effective multidisciplinary working with staff, teams and services working together to deliver care and treatment to meet the patient's needs. Different departments worked together to provide some one stop clinics.
- Radiography services were available 24 hours a day to meet urgent diagnostic needs across the trust, with senior radiology staff being available if required.
- Staff had a good understanding and applied the principles of obtaining patient consent to prior to treatment.

However, we also found:

- Data from the trust showed not all staff had received an annual appraisal as an opportunity to review practice and continue to develop in their role both personally and professionally. In particular, administrative staff did not benefit from regular or meaningful appraisals.
- There were delays in staff sending clinic letters to GPs and patients following an appointment, some specialities had significant delays and significant numbers of letters waiting to be typed.
- Electronic systems used by staff in both outpatients and diagnostic imaging were not effective in providing staff the information they needed in order to do their job. In particular, the picture archiving and communications system (PACS) and radiology information system (RIS) had caused delays in the review and reporting of images.

Evidence-based care and treatment

- Staff used national guidelines for the insertion of peripherally inserted central catheters otherwise known as PIC lines. Staff conducted the procedure under sterile conditions in an air-conditioned scanning room in accordance with national guidance.
- Advanced care practitioners (ACP) authored the trust abdominal aortic aneurysm (AAA) and PIC line guidelines. Staff accessed the guidelines on the trust intranet and found them easily accessible. We saw the guidelines were within expiry date meaning staff had reviewed them in the last two years as per trust policy and reflected the latest national institute for health and care excellence (NICE) guidelines.
- We reviewed eight sets of cardiology guidelines and saw all eight had expired in February 2013 when they were due for review. Consultants we spoke with said they would begin reviewing them immediately. We noted however, the guidelines were still based on the latest national guidelines meaning there was no immediate risk to patients
- Staff conducted stress echoes in a treadmill testing room with electrocardiogram (ECG) monitoring. Dobutamine (drug used in the treatment of heart failure) for stress testing was administered by the physiologists in accordance with written trust guidelines and annual re-accreditation.
- In May 2016, the trust introduced an action plan to develop and implement local safety standards by July 2017. The trust had identified staff to take this forward within the relevant areas of the trust. This was in response to the September 2015, national safety standards for invasive procedures (NatSSIPS). The evidenced based standards are applicable to invasive procedures carried out within the outpatients department and aims to reduce the number of patient safety incidents related to invasive procedures. There was a requirement for all organisations providing NHS funded care to implement local safety standards for invasive procedures.

Evidence-based care and treatment – Diagnostic Imaging

- We saw a number of audits carried out in the diagnostic imaging department. We reviewed an audit of neonatal x-ray image quality conducted in July 2015 and re-audited in November 2015. We saw feedback from two radiologist audits. One audit looked at lens irradiation on computerised tomography (CT) heads. Staff formulated and action plan and recommended an adjustment of practice by the CT staff.
- We saw mandatory audits of the world health organisation (WHO) checklist and the compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) for the recording of reports by clinicians outside of radiology. One audit showed 100% compliance by doctors in fracture clinic.
- In CT an audit was undertaken to establish time from referral to CT scan for ED patients which was documented as between six and 30 minutes
- The trust had established national diagnostic reference levels (DRLs) within radiology. DRLs are typical doses for examinations commonly performed in Radiology departments. They were set at a level so roughly 75% of examinations were lower than the relevant DRL. Trusts should not directly compare national DRLs to individual doses but staff can use them as a signpost to indicate when equipment is not operating correctly. We saw these DRLs listed in folders next to control panels in the department.
- In ultrasound, we saw sonographers performed regular discrepancy audits carried out as per BMUS (British Medical Ultrasound Society) recommendations. Sonographers performed them retrospectively on a three monthly basis. Staff discussed results at discrepancy meetings as well as individual cases. The results of the June 2016 audit identified three reporting discrepancies but this was not a significant figure, the governance arrangements to manage discrepancies was robust and led by the clinical specialist.
- The ultrasound department conducted regular audits, which included image quality and hand hygiene. Results indicated 95% compliance against acceptable standards.
- The sign off and maintenance of research studies was streamlined. The service highlighted research and medical physics performed feasibility studies, compliance checks and ethics approval.
- We saw use of the WHO checklist in the interventional suite. A recent audit demonstrated 100% compliance with the checklist. This was better than the 2015 audit, which demonstrated 98% compliance.
- Radiologists held discrepancy meetings regularly in line with the Royal College of Radiologists guidelines. We

saw the results of an audit carried out in May 2016, which demonstrated seven discrepancies. There was robust governance around this process and figures were below the acceptable 5% discrepancy rate.
- The breast-screening programme conducted robust and regular audits of the breast unit. The service undertook regular quality assurance (QA) and peer reviews of the service.
- Nuclear medicine undertook regular audits including radioiodine usage to ensure women were receiving the correct dosage.

Pain relief

- Staff could access simple pain relief if they assessed patients as being in pain whilst in clinics. During procedures, staff monitored patients for signs of pain. This included observation and asking patients questions about their pain levels. Staff used local anaesthetic to maintain patient comfort during procedures where necessary. Staff provided patient advice on suitable pain relief patients could take after they return home.
- Some ophthalmology patients needed monthly injections. Staff advised patients to report immediately any pain, reduced vision, swelling, redness or discharge after the procedure.
- The royle eye department used local anaesthetic eye drops for some procedures. The department had three nurse prescribers and doctors who could prescribe further pain relief such as paracetamol.
- Staff provided patients with information on pain management. For patients using breast services staff provided with contact numbers if patients experienced any pain or discomfort.

Patient outcomes

- Endophthalmitis is an inflammation of the internal tissues of the eye. It is a possible complication of surgery or intraocular injections, with possible loss of vision and the eye itself. The rate of endophthalmitis nationally following injection is of the order of 1:1000. Audits conducted by the trust showed the trust rate of endophthalmitis post cataract surgery was zero percent. This was better than audits conducted by other organisations for example, the European Society of Cataract & Refractive Surgeons (ESCRS) 0.06%.
- Outpatient services had processes in place to record patient outcomes after each clinic appointment. The service used an electronic outcome form, which consultants were supposed to fill out at the end of every appointment. The outcome form recorded whether the patient required another appointment, referred to another service or discharged for example.
- Patients received specialist diabetic foot clinics at Pilgrim Hospital. The trust had participated in the national diabetic foot care audit. This audit monitored patient outcomes after 12 weeks of receiving

this audit monitored patient outcomes after 12 weeks of receiving their first specialist foot assessment. The latest audit (March 2016) showed at 12 weeks, 11 patients (84.6%) had still had foot ulceration, compared to a national average of 49.5%. Two patients (15.4%) were ulcer free at 12 weeks compared to a national average of 44%.

- The trust used an electronic outcomes system to capture the outcome of patient's clinic appointments. The trust was introducing the system to all departments at the time of our inspection. After each clinic, consultants should complete an electronic form to highlight next steps in the patient's treatment and care. Options included consultants referring patients for another appointment or discharging patients. We saw consultants did not always complete outcome forms in a timely manner.

Competent staff

- Departments were not meeting trust targets for appraisal completion rates meaning that not all staff received appraisals in a timely manner. The target for appraisal completion rates was 95%. Data from the trust showed for the year ending 31 October 2016 staff appraisal rates for outpatient staff at Pilgrim hospital was 66.4%. The lowest appraisal completion rates were for administrative and clerical staff with a completion rate of 47.61%. However, the main outpatient appraisal rates for all staff were 92% and the royle eye department 83%. This highlighted issues regarding the numbers of administrative staff receiving yearly appraisals.
- Some administrative staff said appraisals were not meaningful. Some staff said they had not signed their appraisals and did not know where managers kept their appraisals. Staff said targets and goals were not individualised or not set. Managers kept electronic copies of appraisal forms. We asked managers to view four appraisals. Two were in date and signed by staff but

were standardised with the same goals and targets. Managers could not find the most recent appraisals for two members of staff and could only find appraisals from 2014 and early 2015.
- Outpatient departments used specialist nurses in clinic for example three specialist nurses ran nine vascular clinics Monday to Friday alongside consultant clinics and the breast unit had a clinical nurse specialist.
- Nursing and healthcare support workers said they had opportunities to learn new skills and develop. For example, one healthcare support worker (HCSW) told us they received training in performing an electrocardiogram (ECG) and taking blood samples from patients. Another HCSW told us senior nurses had put her forward to train and develop into nursing associates. Nursing associates were new nationally developed roles, which enabled staff to progress towards a full nursing qualification.
- Staff said managers and senior nurses supported them with revalidation. Staff said managers and their peers were supportive and staff discussed their reflective work with each other.
- Link nurses enabled clinic areas to keep up to date with key changes in practice. Staff in outpatient areas had link roles for example, in areas such as infection prevention and control, health and safety and safeguarding.
- Physiologists working in the cardiology department had to submit portfolios to demonstrate their competencies. Physiologists we spoke with said managers supported their learning and development portfolios. Managers reviewed and signed off their competencies.

Competent staff – Diagnostic Imaging

- The overall appraisal completion rate for diagnostic imaging departments was 88%.
- We saw completed training competencies for some radiographers. We also saw evidence of locum radiographer training and sign off by their supervisor. We saw radiologist competency checklists. The department expected locum staff to complete the same checklists. This helped locum staff meet the same standards and requirements as substantive staff.
- We saw evidence of training for non-radiology staff using radiology equipment such as the vascular and orthopaedic surgeons. We saw evidence of training relating to IR(ME)R and equipment competencies.
- We could not find the training file in nuclear medicine. However, we saw an electronic template for equipment training. There were completed records available to view electronically therefore we were assured staff had received appropriate training.
- In ultrasound, we saw training records with associated scopes of practice. There was no specific documentation relating to equipment specific training except for radiologists but all staff attended applications training on all ultrasound machines. However, we did not see evidence of managers formally recording the training.
- The hospital had recently appointed a clinical specialist sonographer who undertook thyroid fine needle aspiration (a procedure used to detect cancer in a thyroid nodule or to treat thyroid cysts). This was a specialist role and the sonographer worked with their counterpart in Lincoln.
- Staff said they had the opportunity to develop and undertake further training. For example, two sonographers were training to undertake musculoskeletal imaging.
- We saw training records for breast unit staff to ensure they were competent to use the mobile breast-screening van.
- The trust worked with universities regarding the training of sonographers at the trust. The trust and had close relationships with lecturers at a particular university to aid the learning and development of staff. The trust had apprentice schemes and training available for local people wishing to join the service.
- The trust was training one mammographer to specialise in performing biopsies because a part-time radiologist was the only other member of staff who undertook this work. This would then fill the gap left by the radiologist and perform more biopsies across the month.

Multidisciplinary working

- Some departments ran one-stop multi-disciplinary clinics for patients. For example, there was a one-stop shoulder clinic, which involved diagnostic, consultant nursing and physiotherapy staff. This demonstrated a multi-disciplinary approach to patient care ensuring all staff required to input into patient care.
- The fracture clinic worked with different multi-disciplinary teams due to the varied nature of their work. Staff in the fracture clinics worked with

physiotherapists to ensure patients received ongoing care and treatment. The department had a good relationship with the emergency department (ED) and provided training to nurses working in ED.
- The breast unit took part in weekly multidisciplinary meetings. Every week on a Tuesday was breast results day where patients came to clinics to receive results of tests and scans. The MDT meetings included consultants, nurses, therapy and diagnostic imaging staff. Staff discussed each patient individually and consultants highlighted any patients receiving bad news so staff in the clinic could be prepared.
- The ultrasound department had established links with Lincoln and there was a monthly radiology operational meeting with regular telephone contact. The radiologists and sonographers had strong links and working relationships. Sonographers had access to radiologists as required.

Seven-day services

- The ophthalmology clinic ran emergency clinics Monday to Friday 8am to 8pm and 9am to 5pm at weekends. The service mostly received referrals from optometrists, GPs, emergency department and minor injuries units.
- The magnetic resonance imaging (MRI) scanner was open Monday to Saturday 7.20am to 8.30pm and open on Sunday as overtime for radiographers. There was 24-hour diagnostic imaging cover for inpatient wards and the emergency department. There was an interventional radiologist on call service.
- The CT department was open 8.00am to 6.00pm Monday to Friday and 8.30am to 5.00pm on Saturdays. There was also 24 hour cover for emergency CT scans
- The ultrasound department was open from 8.00am until 6.00pm Monday to Friday

Access to information

- Following a consultation medical staff dictated the clinic letters either on to a tape machine or by using a digital dictation system. The timeframe within which letters were typed depended on the urgency of the letter. Urgent letters were completed within 48 hours and non-urgent within 10 working days.
- There were delays across many specialities in the typing of clinic letters. This meant GPs were not getting clinic letters on time. Delays were due to lack of administrative staff and delays in consultants signing off letters. For example, we saw there were 177 letters waiting to be typed or for consultants sign off for maxillofacial clinics and 952 orthopaedic letters waiting to be typed. This presented risks for patients in receiving timely care and treatment out in the community.
- Following the inspection the trust provided a typing recovery plan outlining the action taken to resolve the backlog of clinic letters. Actions included recruiting agency staff, moving staff to work in the busier areas and staff working overtime. However, the recovery plan dated back to 2014, which demonstrated this was not a new problem.
- Staff kept case notes in the secretary's office until clinic consultants approved clinic letters. Staff sent an electronic copy to the GP and a copy printed and put in the case notes. However, because of delays, if another department called up notes or because the patient arrived for a follow up appointment then notes went without staff adding a copy of the letter.
- Staff used a patient administration system (PAS) to manage appointments and patient information. Staff used the PAS to track and locate patient records. When staff received patient records, they were supposed to update the location on the system. However, staff told us they still had difficulty locating records because of storage issues, incorrect information and we saw there were several patient records for the same patient across different sites. This meant it was difficult to locate and access the correct patient information.

Access to information – Diagnostic Imaging

- The trust was part of a radiology consortium and replaced the picture archiving and communications system (PACS) and radiology information system (RIS) to enable images and the trust to share reports across the consortium trusts. During the installation and the four months following, the trust had been experiencing severe issues with the stability of the PACS, RIS and reporting system. This had meant the IT systems were unavailable to various members of staff across the trust to review and report on images in a timely manner.
- Staff could access information about research studies on the radiology intranet. Staff highlighted requests for research imaging with a green sticker to make them easily detectable. Staff could find protocols for these studies on the radiology intranet.

Outpatients and diagnostic imaging

- Radiographers said there were no facilities to transfer images out of hours when the hospital transferred patients in or out to other hospitals. This meant there might be a delay in receiving or sending important patient information.
- Referrers could access an electronic guidance tool written by the Royal College of Radiologists through the trust intranet.
- Departments had IR(ME)R procedures and all documentation was available on a shared drive. This ensured only the most recent versions were available for staff to reference.
- Staff working on the mobile service reported MRI scans undertaken on the mobile imaging van and emailed to relevant secretaries. Secretaries sent the results to radiology to be transcribed onto the RIS.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with understood consent and their responsibilities in terms of gaining patients consent. All staff we spoke with knew about mental capacity assessments and best interest decisions and in what situations staff used them. All staff said they would seek patient consent before engaging in treatment and care.
- We observed staff seeking patients consent prior to delivering care. Staff provided sufficient explanation to enable patients to make an informed decision. Staff obtained written consent for more complex procedures.
- The vascular service based their consent forms on the world health organisation (WHO) checklist adapted for vascular procedures.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- Staff respected patient's privacy and dignity by closing doors, using privacy curtains and ensuring consultations took place in a suitable environment. Patients had access to modesty gowns when receiving care and treatment.
- Patients we spoke with said staff informed them about their condition and plans of care and staff took the time to ensure patients understood what staff had said. Patients said staff were, friendly and caring.
- We saw positive interactions between staff and patients. Staff smiled and introduced themselves upon first meeting patients and we saw staff assisting patients with mobility issues.
- Staff supported patients when patients received bad news or were upset. Staff allowed patients time and space in private to process bad news. Staff used private rooms to give patients privacy and dignity.

However, we also found:

- We saw patients walking barefoot through the x-ray department, which compromised patient dignity.

Compassionate care

- The NHS Friends and Family Test (FFT) gives every patient the opportunity to feed back on the quality of services. Outpatient departments collected their own FFT data so patients and staff could see the scores for their area. We reviewed the NHS Friends and Family Test (FFT) results for outpatient services for the period April 2016 to September 2016.. Results from this reporting period showed hospital performance varied between 91% and 93% of respondents would recommend the NHS service they had received to friends and family.
- Patients told us staff were friendly and caring. We saw caring interactions between staff and patients. Staff in nuclear medicine were polite and helpful. We saw patient comment boards in clinic areas had many compliments from patients on them.
- Staff respected patient privacy and dignity and we observed staff closing doors, using curtains when talking to or examining patients.
- Staff we spoke with described their passion for providing good patient care and building relationships with long-term patients. We saw staff talking to patients in a familiar manner and asking about family members.
- Patients who had limited mobility were shown understanding and patience when they were moving between different areas of the clinics. Staff offered assistance while respecting the patient's wishes to be independent and walk if a patient had mobility difficulties.
- Staff in outpatient and diagnostic imaging services ensured patients had chaperones, especially for

intimate procedures. Staff asked patients if they required a chaperone. In addition, senior nurses ensured chaperones were available and the same sex as the service user through staffing clinics with enough staff to meet demand. We saw medical and nursing staff offered patients the opportunities to have chaperones in patient records.

- The service used volunteers to support patients and help guide them around hospital. Volunteers talked to patients, were friendly, smiled and reassured patients in waiting areas.
- Staff provided patients with refreshments when there were delays in clinics and asked if patients were comfortable.
- Radiology staff used gowns to protect patient's dignity when receiving treatment. A member of the radiology staff personally made gowns for paediatric patients.
- However, we did see patients in imaging departments walking barefoot from changing rooms into x-ray rooms. This compromised patient dignity.
- Due to the environment and proximity of rooms, it was possible to overhear conversations in neighbouring rooms. However, staff kept their voices to a minimum to preserve patient confidentiality and was mindful not to disturb other patients.

Understanding and involvement of patients and those close to them

- Staff informed patients about the examinations they were undergoing and about onward care and results availability. Patients we spoke with said they felt well informed about what was happening.
- We observed staff involving patients in their care and treatment. We saw staff explaining what was going to happen and ensuring patients understood what staff told them. Patients said staff gave them opportunities to ask questions and clarify anything they did not understand.
- All staff understood patient's personal commitments and we saw examples of staff attempting to fit appointments around patient lifestyles and commitments such as work or children.

Emotional support

- Staff referred patients to counselling services when patients required further support in the event of bad news. In urology outpatients, staff used private rooms available when staff gave patients bad news. Staff in the breast unit used a dedicated quiet room where they broke bad news, talked and sat with patients. Staff allowed patients as much time as they needed after bad news before going home.
- Nurse specialists were available for some services, for example the breast unit, to support patients especially when they received bad news. Staff told us wherever possible they would provide support to patients and would ensure if patients wanted a quiet area to reflect then they would make this possible.
- The hospital had a chaplaincy service, which staff used or signposted patients to if they required spiritual support.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There had been delays in the reporting of diagnostic imaging results due to technical difficulties. This affected patients receiving timely access to care and treatment.
- Patients did not access services in a timely way for an initial assessment, diagnosis or treatment. During 2016, the trust has failed to meet the majority of the national standards for the cancer referral to treatment targets. This included the referral standard for patients suspected of cancer who needed to be seen with two weeks. This standard had not been consistently met during 2016.
- The trust had failed to meet the national standard for the referral to treatment time for incomplete pathways for three consecutive months. The numbers of patients waiting over 18 weeks had increased.
- Data from the trust showed significant delays in patients receiving follow up outpatient appointments across several specialities with 3,772 appointments being overdue by more than six weeks. These do not include the patients identified as missing from the waiting lists.
- The environment presented challenges in the delivery of some clinics. Some waiting areas were small and some

areas were not appropriate for wheelchair access because of the age and design of the building. Demand for some clinics exceeded the amount of space for example staff delivering visual acuity clinics.
- We saw staff overbooked clinics in order to accommodate demand and urgent appointments. This led to patients receiving long waiting times in some clinics. The booking system was not always flexible to meet patient needs.

However, we also found:

- Services were planned to meet the needs of local people. For example, the hospital had a dedicated outpatient breast unit. Some specialities planned their clinics around bus timetables and diagnostic services provided patients with a choice of location for their scans.
- Some clinics were trialling new ways of working to meet demands for clinics and to combat overdue appointments. For example, we saw specialties use triage, virtual, and telephone clinics.
- Staff had access to translation and interpretation services.
- The physiotherapy department utilised their hydro pool to put on extra clinics.
- Staff had a positive attitude and culture towards complaints. Staff tried to resolve any issues locally before referring patients to the trust complaints process. We saw staff take positive action and learning from complaints.

Service planning and delivery to meet the needs of local people

- Pilgrim hospital had a dedicated breast unit as part of its outpatient and diagnostic services. The unit served patients referred symptomatically from their GP and those who require further assessment following their three yearly breast screening mammogram. Staff performed surveillance mammography for breast cancer and family history, and those eligible for breast screening in the unit. The unit provided prosthetic fitting, counselling and lymphoedema services for their patients.
- The breast unit had a dedicated quiet room for patients towards to the rear of the unit. The room was equipped with comfortable seating, provision for drinks and the service had decorated it to create a more intimate atmosphere and environment. The room also had a vanity unit (a hidden sink and mirror) patients used to wash or freshen up if they had been upset. The location of the room also meant patients who were upset could leave using an exit door at the back of the unit and therefore not having to walk back out past other patients in the main reception.
- The cardiology department had two dedicated echocardiography scanning rooms, and additional mobile scanners for use on the wards and occasionally during treadmill testing. The door on one of the scanning rooms was wide enough to push a bed through it. The Boston cardiology department also provided trust wide follow up for patients with implanted defibrillators (ICD) and resynchronisation devices (CRT).
- The hospital delivered outpatient services to patients on one floor. Therefore, patients were not required to use lifts or stairs and made services accessible to patients and those with disabilities.
- However, parts of the environment presented challenges in delivering services, waiting areas and wheelchair access. This was because the services delivered were located in an older building. For example some areas in and around the main outpatients departments, including some corridors were too narrow to fit wheelchairs through. Staff mitigated this by ensuring clinics for wheelchair users were located in areas more accessible. The royle eye department waiting area also did not have enough room for wheelchair users. Staff accommodated this by moving chairs.
- The ophthalmology department had two visual acuity rooms. The department needed more rooms to meet increasing demand. Because the department was short of space, they kept the resuscitation trolley in a visual acuity room. This meant should staff require access to the trolley patients would be disturbed in clinic.
- The trust had stopped the pacemaker implantation service at Boston after our last inspection because one of two consultant operators resigned. National guidelines indicate that there must be two operators. The service never restarted and the trust performed all pacemaker implants for the county at the Lincolnshire Heart Centre at Lincoln Hospital, along with all other invasive cardiac services.
- The outpatient departments were well signposted. We saw patients had access to food, drinks from a café and toilets in the large main outpatients waiting area and a

children's play area. There were drinks machines in other outpatient waiting areas and access to water. Waiting areas were comfortable and in most areas, patients had access to entertainment including televisions and books/magazines.
- Outpatient services at the hospitals used volunteers to help patients with the self-check-in system, information, and finding their way around the department.
- The cardiology and dermatology services introduced virtual clinics to review patients overdue for appointment. This involved selecting patients waiting for an appointment reviewing their notes and consultants deciding whether to discharge, conduct a telephone clinic, or to see at another clinic appointment.
- The cardiology department ran advice and guidance through the electronic referral system for new referrals. GPs could refer patients to this service before the need to allocate an appointment. This was an attempt to redirect patients to the right services or to get the right care without having to come in to hospital for an appointment. Therefore, this could contribute to reducing waiting times for other patients.

Service planning and delivery to meet the needs of local people- Diagnostic Imaging

- In June 2016, the trust joined a radiology consortium with six other NHS trusts in the East Midlands. The consortium had vanguard status and national funding. The consortium replaced the trust picture archiving and communications system (PACS) and radiology information system (RIS) to enable the trust to share images and reports across the consortium trusts. This would allow outsourcing of reporting amongst the trusts supporting the capacity and cost reduction required to sustain timely radiology reporting. The trust would have access to more specialised reporting across the region. At the time of the inspection, the consortium was still in its infancy.
- In nuclear medicine, the service offered a limited number of procedures to patients due to the administration of radioactive substances advisory committee (ARSAC) licence holder not being licenced for non-routine nuclear medicine examinations. ARSAC advises government on the certification of doctors and dentists who want to use radioactive medicinal products on people.
- A mobile MRI service visited the trust three weeks out of four. The service was on site for between four and five days. They did not undertake any cancer patient examinations or those involving contrast.
- The hospital had breast screening and symptomatic services offered. Staff delivered services from a specialised unit near the main outpatient department. The unit was well signposted. A surgeon reviewed fast track patients and all reporting was undertaken at Lincoln Hospital.
- The paediatric waiting area was well equipped, decorated appropriately and had age appropriate toys and activities for younger patients.

Access and flow

- A significant number of people did not have timely access to initial assessment of their condition or timely access to follow up appointments for on-going care or treatment. Where there is a delay in patient's attending their first or follow up outpatient appointment there is a potential risk to patient safety. This is because a delay in receiving treatment may lead to a patient's condition deteriorating or not being as responsive to the treatment as it would have been if they had received treatment sooner.
- There is a requirement for trusts to know how long patients are waiting for their outpatient appointments and to manage the services they provide to ensure patients waiting for and receiving care are safe. The time patients wait from a referral by their GP or other health care professional until a patient receives their first definitive treatment is known as the referral to treatment time.
- The trust's referral to treatment time (RTT) for non – admitted pathways had been worse than the England overall performance for the period July 2015 to September 2016.There is no national operational performance standard for this data however, CQC monitor this data as part of their assessment of timely access to care and treatment for patients. 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.
- The incomplete pathway operational standard is the measure of patients' constitutional right to start treatment within 18 weeks. No one should wait longer than 52 weeks for treatment. The trust reported during the week of the inspection five patients had been waiting 52 weeks or more for their appointment.
- 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 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 position within the breast service during July and August had been anticipated by the service as a result of significant capacity deficits within Radiology Services during this time.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%.
- Patients had timely access to diagnostic services; however there had been significant delays in some patients receiving their investigation results. Between July 2015 and June 2016 the percentage of patients waiting more than six weeks for a diagnostic test was lower than the England average. A diagnostic test was a test or procedure to identify a patient's disease or condition to allow a medical diagnosis to be made, for example an ultra sound scan. As of July 2016, 7,288 patients had been referred and were waiting for a diagnostic test, 79 of these patients (1.1%) had been waiting longer than six weeks.
- Managers reviewed the numbers of overdue patients waiting for appointments on a weekly basis and sent reports to each specialty. Actions taken by the trust to minimise the time patients waited for treatment included holding additional clinics and holding virtual clinics. These were when medical staff reviewed the patient's notes and investigation results without the patient attending the outpatient department. Virtual clinics were taking place in several specialities, including dermatology, cardiology and urology. Patients and their GP were informed of the outcome of their review and the need to attend further appointments by letter.
- Vacant clinic slots were actively managed to help minimise waiting times by making best use of the available clinics. Clinic utilisation had been identified as one of the work streams within the outpatient transformation programme.
- The appointment system was accessible to both patients and health care professionals. The majority of new outpatient appointments were booked via the NHS e-referral service. This was an on line booking portal that could be accessed by both GPs and patients. This system provided the referrer or patient with information on the availability of appointments.
- The appointment system was not flexible to accommodate some patient's needs. For example, patients who had multiple appointments on the same day did not necessarily have them one after another. Some patients told us they had one appointment in the

morning and another at the end of the day. A parent said they could not arrange a clinic appointment around their child's school timetable. Staff confirmed they tried to accommodate patients but this was not always possible. This meant patients waited in the hospital most of the day to attend outpatient appointments.

- Between March 2015 and February 2016 did not attend (DNA) rates for Pilgrim Hospital were worse than the England average of 7% until November 2015. Since then the hospital displayed changeable performance and data from the trust showed the DNA rate was 8% at the time of our inspection.
- The trust's policy when patients did not attend for their appointment was part of their patient access policy. In line with this policy where patients had not attended for their appointment the consultant reviewed their records and a decision was made regarding further appointments. We spoke with staff about the DNA procedure and they confirmed it was managed in line with the trust policy.
- If a decision was made not to offer a patient another appointment then a letter was sent to the patients GP and the patient informing them of and the reason why this decision had been made. Patients could be re referred by their GP.
- In the case of vulnerable adults and children, consultants would not discharge patients and instead contact carers, local authorities, and district or school nurses. Therefore, departments would offer patients most at risk the choice to access outpatient services.
- Outpatient clinics had a text reminder service to remind patients about their appointments to try to prevent patients DNAs
- Follow up appointments were managed via a partial booking waiting list (PBWL) system. This was where patients requiring a follow up appointment within six weeks of their current clinic appointment would receive an appointment before they left the hospital. If a follow up appointment was required after this date then patients were sent an appointment through the post.
- Telephone calls made to the trust to book, amend or cancel appointments were managed by the choice and access department. From February to July 2016 an average of 7,570 calls were made to this department per month with an average of 93% being answered.
- Additional clinics to meet the high demand for appointments were held at weekends however there were no scheduled evening or weekend clinics.
- Urgent referrals for example those where cancer was suspected were identified by the referring GP as requiring an appointment within two weeks of the referral. These appointments were then given highest priority when clinics slots were allocated. A proportion of clinic slots were pre-allocated for urgent referrals so these would be available for urgent referrals received within a few days of the clinic date.
- Clinics were cancelled when there was insufficient staff to hold the clinic. Cancellations had to be authorised by a senior business unit manager. Data supplied by the trust for April to July 2016, showed of the 41,472 scheduled clinics sessions across all sites 1,387 (3.3%) were cancelled within six weeks of the clinic date. The cancellation rate for Pilgrim Hospital was 3.18%, which was better than the trust rate. There were 400 clinics out of 12,577 cancelled within six weeks.
- The main reasons for cancellations, as reported by the trust, were 'not listed or not set'. This related to 41% of cancellations. However, 33% of cancellations were due to consultant on annual leave and 7% of cancellations were due to consultants being on call.
- During our inspection, we saw five cancelled clinics. We saw two clinics cancelled within six weeks of the clinic date. One patient turned up for a cancelled clinic and not been notified of the cancellation.
- Staff told us about patients who had been inappropriately cancelled. We saw administrative staff in one specialty had cancelled a patient appointment due on 9 September 2016 and their appointment moved. The patient was due a four-week tracheostomy tube change and guidelines state the regularity of tube changes depends on the seriousness and manufacturer recommendations. The specialty has not notified the patient they had moved the appointment to 23 September 2016, almost two weeks later.
- As of 31 July 2016, the trust reported 13% of patients waited over 30 minutes to see a clinician. We saw some clinics had patients waiting over 30 minutes for their appointment. Staff announced waiting times to clinics when the wait was over 30 minutes. We spoke to one patient who had waited over two hours. They confirmed staff had informed them of the wait.

Access and flow – Diagnostic Imaging

- In the three months following the PACS and RIS upgrade, the trust experienced issues with the reliability of the IT systems. Radiologists said this had significantly

affected patient care due to delays in reporting images. During the initial period when staff first used the system it was unstable and crashed on a frequent basis. This affected the productivity of the radiologists. This affected some national targets highlighted earlier in this report.

- The system issues affected the trust's productivity and turnaround of radiology reports and the availability of images for outsourcing for normal reporting. Three months after the trust changed to the new PACS and RIS system (30 September 2016) 6181 the trust reported patients had delayed imaging reports across all trust sites. This mainly consisted of plain film images with 3,622 patients waiting six weeks or over (2653 over eight weeks). Computed tomography (CT) had 79 patients in the backlog with 18 patients waiting more than eight weeks and four patients waiting six to eight weeks. Ninety-nine patients were within the magnetic resonance imaging (MRI) reporting backlog with nine patients waiting between six and eight weeks and eight patients waiting more than eight weeks. The remainder consisted of imported films from other trusts.
- The trust introduced a method of prioritising reporting based on risk. The trust prioritised all cancer imaging and reported within ten days, and urgent imaging within 15 days. Critical and urgent inpatient scans and emergency department (ED) scans were reported almost immediately where possible. The referring clinician reviewed all plain film images for patients attending clinics with a formal report taking up to eight weeks. These were patients deemed the least risk.
- We saw recovery plans for the reporting backlog. The plans included increasing internal reporting capacity through overtime and additional radiologist reporting sessions and an increase in numbers of images outsourced for reporting by external companies. The trust believed the backlog would be reduced to the pre-go-live levels by December 2016.
- At the time of the inspection staff said, many of the problems with the IT systems had been fully resolved. The system was now reliable and reporting productivity had significantly improved.
- Staff had not reported paediatric MRI head scans using general anaesthetic for a six-week period after the installation of the new PACS. Staff did not realise the images were not accessible by the paediatric radiologist contracted to provide this specialist service. Staff told us that as soon as they raised the issue the PACS team addressed the problem.
- Diagnostic tests or procedures are a critical element in the care of most patients. Shorter wait times are of benefit to patients, as they help people get quicker access to the treatments they need. A diagnostic test is a test or procedure to identify a patient's disease or condition to allow staff to make a medical diagnosis, for example an ultrasound scan. Between April 2016 and September 2016 the percentage of patients receiving a diagnostic test in less than six weeks fell from 99.% to 98%. The national standard was 99% and the trust fell below this standard between July 2016 and September 2016. However, this was still better than or in line with the England average.
- There was a full breast service based at Pilgrim Hospital. A surgeon reviewed fast track patients and referred them for imaging and ultrasound. There was a trustwide breast reporting service for breast patients.
- Diagnostic services gave patients the choice of which hospital site they wished to have their scan. However, staff did ask some patients living in between sites to go to a particular site because others may have long waiting lists. This demonstrated providing patient choice of where to access services but also prioritising so patients did not have to wait longer than necessary for their appointment.
- Radiology had dedicated porters during the working day. They used a portering software package on RIS to know when to collect and return patients. We found the portering of patients to and from imaging services to be timely.
- The trust provided GP referred deep vein thrombosis (DVT) patients with rapid access to ultrasound services. DVT is a serious condition that occurs when a blood clot forms in a vein located deep inside the body. Staff reported significant findings immediately to the referrer. Staff assessed ward patients with suspected DVTs in ultrasound as a priority and staff imaged acute medical unit (AMU) patients in the vascular unit by one of three vascular technologists.
- Senior radiology staff attended hospital bed meetings. This helped radiology understand bed issues, which in turn allowed them to prioritise patients coming through the department.

Outpatients and diagnostic imaging

Meeting people's individual needs

- Outpatient services had wheelchairs located at the outpatient entrance for patients with mobility difficulties. All outpatient departments had disabled toilets and facilities.
- Staff used translation and interpretation services (including sign language) for patients with hearing impairments, or language difficulties. We saw staff had some leaflets and information translated into eastern European languages. Staff gave us examples of when they had last used a translator or interpreter. Staff could access telephone translators or arrange for translators to visit the hospital in person.
- The cardiology department occasionally reviewed children for either portable ECG monitoring or for pacemaker checks. A paediatric cardiology team comes from another trust specialising in paediatric cardiology attended regularly for paediatric cardiology clinics.
- Some outpatient services ran one-stop clinics including clinics for carotid (carotid arteries are major blood vessels in the neck that supply blood to the brain, neck, and face) artery checks and abdominal aortic aneurysm (swelling of the aorta artery) clinics. There were one-stop shoulder clinics so patients could access scans and treatment in the same day without having to come back for other appointments.
- The cardiology department scheduled some clinics around bus timetables to accommodate for patients living in remote areas. Staff knew some parts of the surrounding area only had two buses per day in to Boston and back. Therefore, staff planned clinics around the bus timetable.
- We saw there was plenty of information for patients on noticeboards and leaflet racks. Patient information included the outpatient appointment system, information on specific conditions, and self-care. The trust had specific information for carers.
- Patients requiring special assistance for example patients living with dementia, learning disabilities, impairments or mobility issues could be identified before arriving at clinic. Patients who had attended clinics before had alerts placed in their records and on the electronic booking system. GPs, consultants, relatives or carers alerted staff of new patients requiring special assistance. This meant staff could put special arrangements in place before the patient arrived at clinic.
- Staff gave us examples of how they met patient's individual needs. For example, staff fast-tracked patients living with dementia or patients with learning disabilities through clinics to reduce anxiety. Staff ensured there was space for some patients to wait in private in particular patients who were anxious or unable to wait in public waiting areas.
- The physiotherapy department had a hydro pool used for the rehabilitation for patients. The physiotherapy department developed additional sessions for patients who needed a swimming pool as part of their rehabilitation but could not or felt unable to use a public swimming pool. The department also opened the pool up to baby swimming classes.
- The royle eye department had information in different formats for patients with visual impairments including DVDs and large print documents. The information included information about procedures and the department.
- We saw some clinics had hearing loops installed especially where clinics such as ear, nose and throat (ENT) were likely to see patients with hearing difficulties.
- Diagnostic imaging services used paediatric and bariatric gowns for patients to preserve their dignity during treatment and care.
- The trust had one reporting radiographer specialising in appendicular imaging (relating to a limb or limbs) for Boston, Spalding and Skegness hospitals. This meant that radiologists could report procedures that are more complex.

Learning from complaints and concerns

- For the period, June 2015 to May 2016 there had been 11 complaints made about Pilgrim Hospital outpatient and diagnostic imaging services. There was no overall trend of complaints and there was a mixture of complaints about communication, injuries, waiting times, and scanning delays and inappropriate treatment. We saw departments had actions and learning logs in response to complaints.
- We reviewed outpatient department staff meeting minutes, which confirmed that complaints were a standard item agenda each month. Senior nurses made these minutes available to staff in the clinic areas both in hard copy and via email. We saw staff discuss and make changes because of patient concerns and complaints, for example, advice on treatment plans

after a complaint a patient had received the wrong advice from a nurse. Doctors would undertake this. In addition, we saw staff in the main outpatient department introduce higher seating across waiting areas to improve patient comfort.

- Diagnostic imaging services had a quarterly communication book in which managers placed learning from complaints. This meant those staff not present at meetings or not at work could access the information.
- Clinics displayed clear information on how to complain or provide positive feedback to the trust. The trust website gave information on how to complain and where patients should send complaints. The website also provided information on what patients should expect in terms of response times and having a single point of contact.
- Pilgrim Hospital had a patient advice and liaison service (PALS) based in the main hospital reception. The service provided advice and support to patients who had complaints, comments, compliments, and concerns. Patients could contact the service by email, phone, social media and text. Patients we spoke with knew about the service but said they would initially raise issues with staff. All staff we spoke with knew about the PALS service and if they could not resolve concerns locally, they would refer patients to PALS.
- Staff could give examples of when they had to deal with complaints. Examples given included appointment waiting times and clinic cancellations. All staff said they would try to deal with the issues in the clinic however, if patients were not satisfied staff would provide them with details on how to complain. Senior nurses told us they were involved in complaint investigations and providing responses to patients.
- From June 2016, complaints across the trust were peer reviewed by a group with patient and external representatives. This ensured staff had followed the complaints process. This had become a lessons learned forum from July 2016. With trust wide membership and ensures sharing of learning. The trust is also working with London School of Economics on a research project on learning from complaints.

Are outpatient and diagnostic imaging services well-led?

Inadequate

We rated well led as inadequate because:

- The outpatient service had a dedicated strategy. However, it was not underpinned by realistic objectives and plans. Actions to address key issues in meeting organisational targets were overdue or had not been achieved. We saw the hospital had the same identified issues we found during our 2014 and 2015 inspections.
- Governance arrangements and accountabilities for managing performance were unclear. Different business units and departments were accountable and responsible for different elements of outpatient functions and performance. There was no single accountable manager or person responsible for the performance of outpatient services.
- Measures to tackle key risks and performance were ineffective. There had been a lack of oversight of some key risks affecting care and treatment. Significant issues which threatened the delivery of safe, effective, and responsive care were either not identified in a timely manner. Adequate action to manage them was not always taken. For example, actions to deal with the number of patients waiting for appointments and without recorded outcomes did not meet identified timeframes.
- Leaders did not have the knowledge or capacity to lead effectively. The outpatient transformation lead was the only manager who had full knowledge of the risks and issues facing outpatient
- We had concerns regarding staff culture in a number of areas, particularly regarding administrative staff. Morale was low amongst administrative staff and they described a culture of intimidation stating managers were not supportive. There were low levels of satisfaction, high levels of stress and work overload.
- Management and governance arrangements were in transition and outpatient services were undertaking a workforce review. This provided uncertainty for some staff and meant some managers were not clear on their responsibilities.

However, we also found:

- Culture and relationships amongst nursing staff in clinic department were positive. The majority of nursing staff talked about receiving good positive support from their colleagues.
- The majority of staff had an understanding of the key risks and we saw outpatient services had a process for escalating risk.
- We saw good examples of innovation and fundraising from a number of different outpatient departments.

Vision and strategy for this service

- In 2014, the CQC inspection referenced areas that required significant improvement within specific areas of the outpatient service. These improvements related to the environment, tracking and management of patient pathways, and management of waiting lists that had limited visibility. The majority of these improvements related to Lincoln Hospital. The subsequent CQC inspection report of 2015 stated 'the trust must continue to make improvements to ensure that patients receive treatment and care in a timely manner, particularly within outpatients departments'. In response to this, the trust implemented an outpatient improvement programme in 2015 aimed at improving services across both sites.
- To provide clear direction the outpatient service had developed a documented strategy for improving services throughout the trust covering the period 2016 to 2021. This document incorporated and steered the outpatient improvement programme and identified key areas for improvement. These included the utilisation of clinic space, addressing the inconsistency across the booking system, the content, availability and condition of health records. In addition, the strategy highlighted addressing cancellations and the number of delayed or missing clinic outcomes resulting in loss of trust income.
- The trust implemented an outpatient transformation programme in April 2016, which incorporated key elements of the strategy, and the work started in the 2015 to 2016 outpatient improvement programme. The outpatient transformation programme contained five key project areas. These were the outpatient environment, the workforce, the management of follow up patients, systems and processes for example the introduction of e -outcomes and clinic standards and the utilisation of clinics including capacity for and the scheduling of appointments.
- Having completed phase one of the transformation programme, the trust had made some ongoing changes. The trust designed the initial changes to provide a stable platform and structure, which would ultimately contribute to improving outpatient performance. These included the trust moving key administrative functions into the clinical support services business unit and a move towards a single management team responsible for outpatient services. In March 2016, the trust introduced the electronic outcomes system and was still in the process introducing this system to some specialties. The phased introduction of new clinic standards had commenced across the trust sites.
- There was ongoing work to standardise clinic rooms in an attempt to improve the clinic environment Nursing staff said they had seen improvements to outpatient areas as a result of the outpatient improvement programme. The most notable improvement was the introduction of standardised clinics. Standardised clinics meant all departments were to refurbish clinic rooms to the same specification. Therefore, medical and nursing staff could operate from any room and know where to find equipment and items needed to conduct clinics.
- Despite the above achievements, we saw during our inspection and from a transformation programme update, (June 2016) progress had been slow and the programme had not met key targets (including some already revised). In particular the trust had not achieved its targets in relation to overdue appointments and the environment and the transformation programme progress had been RAG (rated red, amber or green to reflect progress) rated red. Work on clinic utilisation was the only work stream on target.
- Half the staff we spoke with did not know about the strategy for outpatient services. Some staff could not tell us about the outpatient improvement programme but knew "things were happening".
- The majority of staff knew about the trust values and the focus on patient centred care. Departments displayed the trust vision and values in clinic areas.
- Part of the strategy for diagnostic imaging services involved moving to a new regional picture archiving and communication system (PACS) and radiology information system (RIS). This would enable staff to

share images and reports across the consortium trusts. This would allow outsourcing of reporting amongst the trusts supporting the capacity and cost reduction required to sustain timely radiology reporting.

- Staff in nuclear medicine said that there had been great disruption to the department following the introduction of the new PACS. Staff felt the strategy was wrong to introduce a number of new IT systems at the same time, which resulted in normal and routine tasks taking much longer than usual. The continuity of the new systems was not good and there were many issues relating to staff accessing systems. Data from the trust showed delays in reporting images because of the introduction of the new systems.

Governance, risk management and quality measurement

- Business units provided, delivered and managed services across the trust. The clinical support business unit managed outpatient and diagnostic imaging services. The business unit was responsible for the delivery and nursing staffing of the majority of clinics, including administrative functions.
- The outpatient and diagnostic imaging structure was in a state of transition at the time of our inspection. This was because outpatient services had recently moved to the clinical support business unit. The clinical director said he had only been responsible for outpatient services for a few months at the time of our inspection. Since our last inspection, managers said there had been several managers responsible for the delivery of outpatient services. Therefore, senior managers in the business unit were still attempting to understand how services worked.
- At the time of our inspection, the business unit was introducing a new management structure for administrative and nursing staff as part of a workforce review. Therefore, some management roles were temporary or new for some managers. This led to some uncertainty amongst staff, particularly administrative staff regarding responsibility and accountability. The aim of the restructure was to provide more accountability for outpatient services, including the back office functions. Managers held engagement meetings with staff regarding the changes.
- The Matron responsible for the main outpatient department had been in their temporary role for five weeks. However, the matron was popular amongst staff and staff said she had brought about positive change. The matron had previously been a senior nurse in the department and therefore was aware of key performance issues within outpatient departments. Senior nursing staff supported the matron in managing all the outpatients departments under the matron's remit. This meant there was adequate management cover for each outpatient department.
- The outpatient transformation programme had identified several key risks and issues affecting patients and outpatient services. The transformation programme had its own risk register. Some of the risks were long standing including health records and some not for example patients incorrectly missing from the partial booking waiting list. The lead for the transformation programme had a good understanding of the risks and escalated concerns to business units, the executive team and various committees responsible for governance and performance. However, this demonstrated the trust had not addressed long-standing risks.
- The majority of staff we spoke with knew about the key risks to their service included on the outpatients (log) and trust risk register. This included the quality and availability of patient records, overdue appointments and environmental challenges. However, the outpatient transformation lead was the only manager we spoke with who had knowledge about strategic risks across the whole of outpatient services. The outpatient transformation programme provided reports and escalated risks to business units and the Operations meeting.
- Other business units across the trust managed the performance of different individual specialties, outpatient functions and clinics. This meant while business units and individual departments managed performance in their own areas there was still no overall oversight or manager accountable for the performance of all outpatient functions. This created a disjointed approach. The outpatient transformation programme had some strategic oversight but this was a temporary programme with a temporary manager.
- We reviewed the trust's patient access policy, which sets out how the trust manages outpatient and diagnostic waiting lists. This policy stated clinical directors and business units were responsible for ensuring the management and safety of patients on the waiting list.

- Managers in the clinical support business unit provided business units with weekly and daily reports on updates on appointment and waiting list issues. The report included the number of patients they identified as time critical, highlighting those who are at the greatest risk from any delay. We saw from minutes of meetings business units reported to the deputy director of performance on progress and actions taken at patient tracking list (PTL) meetings. We saw each business unit had an action plan to address performance issues.
- From reviewing meeting minutes and from speaking to senior members of staff, we established the business units were managing resources to try to meet both an increasing demand for outpatient services and address the significant number of overdue appointments. Whilst the transformation programme had made improvements in the number of patients overdue for appointments, progress had not been as quick as expected. In addition, the number of overdue appointments contributed to new patients waiting longer for their first appointment in several specialities and the trust meeting a third of its cancer referral targets.
- A key aspect of managing the risk to new patient referrals was ensuring a suitably experienced clinician reviewed and graded referrals received to establish timeframes in which they needed to see. This enabled staff to attach the correct degree of urgency to the appointment request. However, we saw the review and grading of new referrals was not always timely.
- The health records department had recently begun to audit the availability of records for the start of clinics. At the time of our inspection on (one) speciality had been completed and another was under way. There was a planned timetable for audits however, because this audit work had just started. managers did not know how many records were unavailable and for which clinics. Therefore, health records staff and managers could not respond appropriately to risks and put actions in place except for when staff raised incidents or provided feedback. The trust had plans to address this through an audit process.
- At our previous inspection, CQC highlighted the lack of quality of patient medical records. We saw on our inspection that this remained a key concern for staff. The quality and size of records affected staff accessing the most appropriate information for patients. Staff said nothing had improved since our last inspection. An escalation report from the clinical records committee (11 October 2016), to the information governance committee highlighted longstanding issues with the quality, availability, and filing of patient records. This report highlighted the trust had the same issues and in some cases the present situation was worse demonstrating a lack of progress.
- Some outpatient departments put in extra clinics during the week, in the evening and at weekends to reduce the number of patients. However, the majority of clinics were responsive and ad hoc. This meant there was additional pressure to recruit additional nursing staff to staff clinics and on medical secretaries to type up clinic letters. This contributed to backlogs in typing up clinic letter in some specialities. In response to this the trust said extra clinics were managed through a planned process via the outpatient capacity meeting.
- During 2016 the trust identified the computerised records may not accurately reflect the number of patients who were actually waiting for treatment. This issue had only recently been discovered and possibly affected patients going back two years and been caused by poor management of the electronic patient administration system. We saw from minutes of the operational performance board (13 October 2016) discussion regarding large numbers of patients potentially waiting for treatment who were not on the electronic waiting list. The trust had started a validation exercise to determine the extent of the problem and actual numbers.
- We spoke to staff providing data validation services to the trust as part of a wider team of 20 staff. They said they had identified patients who had been missing from the PBWL. This posed a risk to patient safety.
- The trust used operations meetings to review referral to treatment times (RTT), cancer targets and incomplete pathways performance. The meetings identified specialties with particular challenges. We saw in board meeting minutes managers presented exception performance reports on key performance issues to the trust board. Managers said they challenged particular specialties who displayed poor performance. However, managers said there were reasons for poor performance including medical staff vacancies or high demand.
- Managers produced daily missing outcome reports to monitor those patients who had incomplete outcomes after their clinic appointment. Managers discussed the report at operations meetings. Managers said some

patients were those waiting for staff to add them to the electronic system after the transition from paper to electronic outcomes. We saw the number of patients without recorded outcomes had increased between October 2015 and October 2016. This meant action taken to address this issue had not been effective.

- We saw there were delays in typing up clinic letters to send to the patient and their GP. In response to this, the trust had a typing recovery plan. The plan identified actions in each speciality and most actions relating to increasing staffing resource to manager backlogs. Some actions dated back to 2014 and we saw business units had completed three out of 19 actions. Most of the actions were ongoing and it was unclear from the action plan how often business units had reviewed and updated them. Data from the trust showed specialities were either in line or worse than projected targets regarding the number of letters waiting to be typed. There had been a 41% reduction in the backlog in th two months prior to our inspection. However, typing delays were a long-standing issue and when the trust made progress it could not always be sustained.
- At the time of our inspection, the trust was trialling an outpatient's performance dashboard as part of the outpatient transformation programme. The dashboard's aim was to improve performance management of key areas of outpatient services. There was a dashboard set up for every speciality. The transformation programme lead had provided individual business units within the trust had a link to the dashboard so they could monitor performance. The dashboard provided speciality specific data including, clinic utilisation levels, non-attendance rates and clinic activity levels. However, the dashboard was still in its early stages of use and therefore business units were not yet using it as a performance management tool.
- At our previous inspection, we raised concerns with the trust regarding the booking system and staff overbooking clinic slots. We saw on inspection overbooking of clinics still occurred and there were problems with the booking system. Problems with the booking system contributed to delays in patients receiving appointments. This demonstrated the trust had not made significant improvements in this area. Following our inspection the trust said problems with the booking system had been largely resolved. However there are isolated incidents which were being actively managed. A planned upgrade was expected during 2017.
- Outpatient and diagnostic departments conducted monthly 'ward health checks' to continuously monitor incidents, complaints, staffing and performance against trust policies such as hand hygiene. Managers published results for individual departments as well as trust wide results. Therefore, managers could highlight key performance issues or risks on a regular basis to staff.

Governance, risk management and quality measurement – Diagnostic Imaging

- The trust had anticipated a short term issue with the new RIS and PACS, but after three months still had a number of technical issues which the trust were not able to resolve. We saw evidence of the management and monitoring of this risk. Managers added the issue to the risk register and escalated appropriately through the quality governance committee.
- Actions to reduce the backlog included prioritisation of scans such as cancers and urgent imaging, increased outsourcing to external reporting companies, and increasing the internal reporting capacity through overtime and additional reporting sessions. Radiographers had carried out a review of the reporting with modality leads monitoring work not done.

Leadership of service

- Administrative staff said they did not think the chief executive or senior managers knew what was going on at their level and local leaders ignored staff concerns and issues. Some managers knew of the concerns and issues but were under "overwhelming pressure" themselves to deliver results.Following our inspection we were told the Chief Executive and senior managers were spending time in all clinical areas with all staff grades in and out of hours. They told us they understood the functionalities of all areas including issues and pressures that have been experienced.
- Some administrative staff said leaders were not visible and during busy periods, managers left their desks together for coffee breaks. Staff said leaders did not offer support or help during busy periods or when staffing was short. Staff claimed leaders went for breaks together which left administrative staff without support. We saw this happen on one occasion.

Outpatients and diagnostic imaging

- Nursing and medical staff felt there was good clinical leadership. Leaders were visible and new members of staff felt part of their team quickly. Nurses and health care support workers said senior nurses were visible and approachable. Staff in particular complimented their new Matron who had the experience and knowledge needed to run the department.
- We saw senior nurses encouraging supportive relationships between staff in their department. A senior nurse in the main outpatient department had introduced a kindness box. The kindness box provided staff the opportunity to compliment and thank each other. We saw discussions in team meeting minutes about supporting individuals and working together as a team.
- The outpatient transformation lead was visible across trust sites. The lead communicated well with key managers in the trust and had knowledge of what they keys issues for outpatient services were. From discussions with other managers across the trust, other managers did not have the same level of understanding and knowledge of outpatient services. The inspection team felt the outpatient transformation lead was the only manager with a full understanding of the service.
- Managers in diagnostic services worked well together and had weekly meetings with each other. This helped managers to gain knowledge and understanding of the key issues affecting staff and the service across the trust.

Culture within the service

- Nine out of 32 members of administrative staff (28%) we spoke with said they had experienced bullying or intimidation by managers. Other staff we spoke with said there was a culture of not sticking to policies or using policies against staff as a form of punishment rather to guide managers. Staff said managers spoke to them inappropriately and were constantly watching them or asked to do things they should not be doing. This behaviour existed at different levels and in different administrative departments.
- We ran a focus group for administrative staff attened by 26 members of staff. Staff at the focus group also referenced initimidation, bullying and inappropaite behaviour by managers.
- Some administrative staff said nursing staff in some clinic areas had intimidated them and made them feel bad or undervalued.
- NHS staff survey 2015 data showed 26.4% of staff at the trust had experienced bullying, harassment or abuse from other staff. This was slightly worse than the average for other trusts 25% and slightly worse than 2014 trust figure (26.2%).
- Twenty eight of the 32 members of administrative staff we spoke with did not feel respected, supported or valued by their managers or senior managers within the trust. Staff perceived managers had forgotten them despite raising incidents and issues regarding staffing numbers, delays in typing up GP letters, issues with storage of records and the risks associated with them. All secretarial staff said they did not feel valued because of a recent down banding of their roles and there had been no support from managers. The majority of staff said they felt stressed and under pressure.
- As a result, there was a lack of focus on the safety and wellbeing of administrative staff. Staff we spoke with mentioned a lack of support during busy periods or being denied screen breaks. This was inconsistent with the vision and values set down by the trust.
- There was a supportive environment amongst nursing staff. All nursing staff we spoke with felt supported and valued by senior nurses. Staff worked collaboratively and communicated well with each other. We saw senior nurses focussing on the safety and wellbeing of their staff and patients.
- The majority of nursing staff we spoke with said they got on well with their colleagues and peers. and Staff said they supported each other especially through periods of challenge and pressure. The majority of staff described a positive working culture with consultants.
- There was a patient centred culture amongst the majority of staff. Staff spoke about wanting to get the best outcomes for patients, make their visits smooth and give them the best experience possible. Staff we spoke talked about openness and honesty with their patients.

Culture within the service- Diagnostic Imaging

- The majority of staff said there was a good culture amongst radiographers. There was a range of ethnic diversity amongst staff and the majority of staff said people from other countries were welcomed into the department.

- Staff across departments said they were proud of how the departments work together. The majority of staff said the way they worked together was a key strength. We saw evidence of strong working relationships between radiologists and radiographers.
- Staff in diagnostic services had a culture of candour and honesty with patients.
- Morale amongst radiologists was low during the difficulties with the PACS and RIS systems. This was because these difficulties caused delays and backlogs in reporting leading to delays in treatment and care of patients. Staff felt un-supported by senior staff and it was highlighted there was a lack of training
- Some staff said despite the trust merging 10 years they did not feel part of the wider trust.

Public engagement

- A member of the public sat on the outpatient transformation steering group to provide a patient perspective to ongoing changes to outpatient services.
- We saw outpatient departments had feedback and comment boxes in reception areas. Staff said they checked the boxes once a month. We saw in one feedback box in the royle eye department was used and had patient feedback cards inside.
- We saw 'you said we did' displays on outpatient notice boards. The notice boards highlighted what staff had done in response to patient feedback. One example we saw was comments from patients regarding the lack of high chairs in waiting areas. We saw staff had placed higher chairs in all waiting areas to aid patient comfort.
- Diagnostic staff worked with local schools to get young people interested in radiography. The trust provided work experience opportunities for young people.
- The nuclear medicine department conducted patient satisfaction audits but they did not form part of the friends and family test data.

Staff engagement

- We spoke with 32 administrative staff from a number of different departments. The majority of administrative staff we spoke with said they did not feel listened to or engaged. They said despite raising concerns and issues managers did not listen to them. Whilst we have no evidence that the trust were stopping staff from speaking out, it is important to reflect staffs perception.
- Most administrative staff we spoke with said they did not have team meetings and managers did not inform them about what was happening in their business units. We requested meeting minutes for some administrative departments and saw meetings managers did not hold meetings regularly.
- Administrative staff said managers did not take staff concerns or ideas seriously. For example, administrative staff wanted a uniform so they could be identifiable within the trust and to the public. This would create a more professional outlook to the public. However, staff said managers had not actioned this and the work staff undertook to present ideas had been stopped.
- We saw evidence of staff engagement and involvement in the outpatient transformation programme. Senior managers within the clinical support services directorate held meetings with staff subject to structural and management changes. Outpatient nursing staff were involved refurbishing and standardising clinic rooms as part of the transformation programme. We saw this work discussed in team meeting minutes.
- Senior nurses listened to staff in the main outpatient department and we saw evidence of changes made because of staff engagement. For example, the department had developed hubs outside clinic rooms where they could use computers and prepare for clinics. In addition, the department moved the drug cupboard out of the ECG room and created a new storeroom to ensure staff requiring drugs did not disturb patients having ECGs.
- Some clinics used a communication diary or folder so staff could review important information and learning they may have missed while away or not on shift.
- Overall, staff were positive about the chief executive and the majority of staff said they read his blog and felt he communicated well with staff.
- Senior nurses used a communication board called 'time to talk' to pass on key information to staff. Information included learning from incidents or complaints, staffing, performance and key trust-wide messages. We saw staff discuss information from the board at daily huddles and the board was visible for all staff to view in their own time. All staff we spoke with liked using this board and said it was a good tool for passing information to staff.
- We saw nursing staff had team meetings. Senior nurses said they tried hard to hold them once a month but it was sometimes difficult due to staffing levels and

demand in clinics. We reviewed four sets of team meeting minutes and saw senior nurses communicated with staff on a number of topics local to the department as well as key trust-wide messages.

- Staff in diagnostic imaging received a bimonthly communications booklet. This was a cross-site bulletin for radiology so staff could keep up to date on areas such as training, health and safety, updates to policy and procedures and best practice techniques.
- Staff in diagnostic imaging had discussed the need for a communications board with managers as part of how managers and the trust communicated messages across the trust.
- Managers in diagnostic imaging held staff meetings bi-monthly. However, staff said these had not occurred for a while. We saw minutes where staff meetings had occurred, staff forums and informal discussions. Overall, staff said they felt engaged by managers and the trust.

Innovation, improvement and sustainability

- The royle eye department had an 'eye-ball' to raise funds for the eye department. Staff, including the chief executive, and patients, attended the ball. The department also celebrated being the best-decorated department at Christmas 2015.
- The orthopaedic department held a charity ball to raise money for the local hospice.
- As part of the outpatient transformation programme the trust were introducing a new electronic patient calling system to Boston outpatient departments. The electronic system (already in use at Lincoln Hospital) linked to the booking in system when patients arrived for clinics. It allowed staff to call patients into clinics using electronic screens. Staff could also use the boards to update patient waiting times or to pass on key information to patients.
- Ultrasound staff were proud of their rapid access deep vein thrombosis (DVT) service they provided to patients.
- The trust was in the process of introducing an electronic referral system to diagnostic imaging. The trust was piloting this system in a few departments. There had been a safety concern highlighted during the pilot, which resulted in staff not using the system. However, radiology management assured us they had addressed the issue.
- Medical physics staff said the trust had plans to install dose-monitoring software. This would make it easier for staff to perform regular dose audits and investigate potential high dose procedures.
- The physiotherapy department utilised its hydro pool to enable patients and the wider community use it for private sessions. The service charged for some sessions therefore generating a small income.

Outstanding practice and areas for improvement

Outstanding practice

- The emergency department was trialling the introduction of a hot meal for those patients who were able to eat at lunchtime.
- 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 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.
- 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.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- 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.

Outstanding practice and areas for improvement

- 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.
- 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.

Outstanding practice and areas for improvement

- 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.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The trust should ensure there are robust systems in place to ensure all incidents are reported, investigations occur in a timely manner, staff receive feedback and processes are in place to ensure learning occurs.
- The trust should ensure that governance procedures are robust, risks are clearly identified and that there is a comprehensive assurance system.
- The trust should ensure ligature cutters are immediately available in the ED.
- The trust should ensure that the resuscitation trolleys and their equipment are checked, properly maintained and fit for purpose in the emergency department.
- The trust should implement the difficult airway trolley in the emergency department at the earliest opportunity.
- The trust should ensure the proper and safe management of medicines, including storage at the correct temperature in the emergency department.
- The trust should ensure it continues to work to response to the increased capacity and improve flow through the emergency department in order to ensure patients are seen by a registered healthcare practitioner in 15 minutes, do not have to wait longer that four hours and that ambulance handovers happen within 15 minutes.
- The trust should ensure there is 16 hours of consultant presence each day.
- The trust should ensure there is a suitable room in ED to treat those patient with mental health needs.
- The trust should consider if mental capacity assessments and best interest decisions for patients attending the emergency department are recorded in line with the Mental Capacity Act.
- The trust should ensure staff are appropriately trained and supported to meet the requirements related to duty of candour.
- The trust should ensure an annual audit is carried out in line with the recommendations of The Royal College of Emergency Medicine (RCEM) guidelines; Management of Pain in Children (revised July 2013).
- The trust should consider how the emergency department can comply with the accessible standard for information and also how facilities for the hard of hearing can be improved at the reception are of the emergency department.
- The trust should consider how the environment in the emergency department could be more dementia friendly.
- The trust should ensure mandatory training is completed in line with trust policy.
- The trust should ensure safeguarding adults and children's training is completed in line with trust policy.
- The trust should ensure standards of hygiene and cleanliness at all times to prevent and protect people from healthcare-associated infection.
- The trust should ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.
- The trust should ensure observation charts for monitoring fluid balance of patients are completed to ensure the health, safety and welfare of the service users.
- The trust should ensure systems, processes, standard operating procedures are in place to ensure documentation, and checklists for the safe delivery of care for patients with a tracheostomy are completed and displayed in accordance with trust policy.
- The trust should ensure evidence based guidance is followed. The trust did not follow national guidance for the administration of rapid tranquilisation medication.
- The trust should ensure staff training on Consent, Mental Capacity Act and Deprivation of Liberty Safeguards is completed in line with trust policy.
- The trust should ensure staff appraisal rates are completed in line with trust policy.
- The trust should ensure patient records are kept securely.
- The trust should ensure all fridge temperatures for the storage of medication are recorded in line with trust policy.

Outstanding practice and areas for improvement

- The trust should ensure staff training on Consent, Mental Capacity Act and Deprivation of Liberty Safeguards is completed in line with the trust target of 95%.
- The trust should ensure do not resuscitate cardio pulmonary resuscitation (DNACPR) orders are completed and mental capacity assessment for those deemed to lack capacity are completed in line with trust policy and national guidance.
- The trust must ensure pain assessments tool are completed for patients in line with evidence based guidance and staff are clear about the specialist pain team referral pathway.
- The trust should ensure systems are robust to identify vulnerable patient groups including, but not exclusive to, patients living with dementia and patients with learning disabilities.
- The trust should ensure there are robust systems in place to manage quality and safety issues in the absence of the Quality and Safety Officer (QSO) for the medicine directorate.
- The trust should ensure patient records are kept securely.
- The trust should ensure all fridge temperatures for the storage of medication are recorded in line with trust policy.
- The trust should ensure that staff vacancies are recruited into to meet the patient acuity within this service.
- The trust should ensure that the emergency call bells on the risk register since 2014 are installed.
- The trust should ensure they review the consultant rota to ensure that the rota is sustainable, and that consultants receive 11 hours rest in line with the European working time directive.
- The trust should ensure there is an allocated physiotherapist to surgical ward areas.
- The trust should ensure that a Psychologist or Counsellor are available to support the vascular amputation patients.
- The trust should ensure that the measures are addressed for the National Emergency Laparotomy Audit.
- The trust should ensure that the safety thermometer is displayed in all areas.
- The trust should ensure that all staff receive a yearly appraisal.
- The trust should ensure they address concerns regarding the clinical waste arrangements with disposal trolley bins permanently outside the theatre corridor.
- The critical care unit should display safety thermometer outcomes within the department so that staff and visitors are informed of safety outcomes for the unit.
- The critical care unit should establish a recorded program of equipment maintenance and capital replacement in line with standards for equipment in critical care.
- Critical care should consider improving links with speech and language therapists to ensure patients are able to swallow effectively following tracheostomy or long term intubation.
- The critical care department should consider increasing the number of staff able to access the post registration award in critical care nursing.
- The senior management team should consider incorporating CCOT into the critical care team to facilitate continuity of care between critical care and the wards.
- Critical care should consider integrating a named medical consultant when caring for emergency medical patients, to ensure continual and consistent treatment for these patients on discharge from the unit.
- Critical care should review the service in line with intensive care standards.
- Critical care should consider collecting data to reflect their delayed discharges by speciality and reason to support this topic on the risk register.
- The trust should take actions to ensure that NICE guidance is followed in the provision of care for patients with hypertensive disorders in pregnancy.
- The trust should ensure that the new IT system supports accurate documentation of safety thermometer data.
- The trust should ensure that notes for patients undergoing caesarean section are consistent including standardised documents.
- The trust should ensure that safeguarding supervision is provided regularly for all staff.
- The trust should ensure that if recent NICE guidance is not followed then the current guidance includes an addendum to explain the current decision. (CG 190)

Outstanding practice and areas for improvement

- The trust should audit the length of time patients attending for emergency gynaecology appointments are expected to wait.
- The trust should take action to improve the provision of multidisciplinary training.
- The trust should ensure that within maternity service users feedback is captured.
- The trust should ensure that action plans are made following audits, and a reaudit is performed, such as following the regular CTG audits.
- The trust should consider delivering more transition clinics for other long-term conditions other than diabetes and cystic fibrosis.
- The trust should ensure they devise an abduction policy for the neonatal unit and children's ward, and test the policy regularly.
- The trust should ensure all staff follow best practice documentation guidance to ensure all entries into clinical notes is of a satisfactory level and in line with professional standards.
- The trust should ensure staff for working in the children and young people's service receive formal clinical supervision.
- The trust should ensure outpatient and diagnostic services are delivered in line with national targets.
- The trust should ensure staff report incidents in line with trust policy.
- The trust should ensure staff are reminded of the procedures regarding fridge temperatures falling outside expected range.
- The trust should take action to ensure all staff working in the outpatient and diagnostic services receive an annual appraisal to ensure they are able to fulfil the requirements of their role.
- The trust should consider whether the action taken to reduce the back log of clinic letters waiting to be sent to GPs and patients following their appointment was effectively resolving the backlog of letters.
- The trust should ensure all staff are supported and are not subject to any behaviour falling outside the trust code of conduct.
- The trust should ensure all staff know their responsibilities and expectations regarding screen breaks.
- The trust should continue to review the progress and effectiveness of the outpatient transformation programme and work undertaken to reduce diagnostic backlogs.
- The trust should ensure staff documented ultrasound probe cleaning.

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 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014: Premises and equipment **Regulation 15 (2)** The provider must, in relation to premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. **How the regulation was not being met:** • There were dusty areas in the resuscitation area were dusty. • The fridge in the patients' kitchen had a sticky substance on one of the shelves, the work surfaces were stained and surgical tape which was visibly dirty had been used to secure a notice. • Monthly cleaning audits did not consistently meet the trusts target. • Daily cleaning checklist were not consistently completed.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014: Safe care and treatment. **Regulation 12 (2) (a) (b)**

This section is primarily information for the provider

Requirement notices

Care and treatment must be provided in a safe way for service users by assessing the risk to the health and safety of service users of receiving care and treatment.

Care and treatment must be provided in a safe way for service users doing all that is reasonably practicable to mitigate any such risks.

How the regulation was not being met:

- Where patient had met the trust's criteria for sepsis screening, not all patients were screened in accordance with national guidance.
- The trust's sepsis protocol was not embedded with all staff groups to achieve and maintain high levels of compliance with sepsis identification treatment.
- Patients whose condition is deteriorating are not consistently escalated appropriately.
- There was no on-call gastrointestinal bleed rota to protect patients from preventable harm.
- Staff did not respond appropriately in administering treatment in the recommended time frame in accordance to the sepsis six bundle of care.

Regulation 12(2)(c)

Care and treatment must be provided in a safe way for service users by ensuring the persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

How the regulation was not being met:

- There were not sufficient numbers of staff with the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department. This did not meet Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings 2012 and Royal College of Nursing Standards 2013.

Regulation 12 (2) (h)

The provider must assess the risk of, and prevent, detect and control the spread of, infections including those that are healthcare associated.

How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

- Not all staff decontaminated hands before or after patient contact.
- Hand hygiene audits were not consistently completed in the emergency department.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014: Good Governance **Regulation 17 (2) (c)** The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. **How the regulation was not being met**: • Risk assessment, pain scores and cannula care were not consistently recorded. • Patient records were not kept securely in ambulatory emergency care unit (AEC).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014: Staffing **Regulation 18 (2) (a)** Staff must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- Not all non- medical staff had an appropriate appraisal

Not all staff had completed mandatory training.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014: Good Governance 17 (1) (a) Systems or processes must be established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) 17 (1) (b) Systems or processes must be established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. **How the regulation was not being met:** • The approach to reviewing and investigating incidents was insufficient and too slow and staff did not report all incidents appropriately. • Governance meeting minutes indicated incidents were not investigated, lessons learnt or shared in a timely way. • Governance and risk management arrangements were not robust and as such were not suitable to protect patients from avoidable harm. The trust was not aware or did not recognise some risks within medicine. These included no availability of a gastrointestinal bleed rota, not all staff were trained as competent to deliver care to patients receiving non-invasive ventilation and tracheostomy care, sepsis six treatment targets were

This section is primarily information for the provider

Requirement notices

not being met, mandatory and safeguarding training was below trust target, ligature risk assessments had not been undertaken and ligature cutters were not available.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 Safe care and treatment (2) (a) Care and treatment must be provided in a safe way for service users by assessing the risk to the health and safety of service users of receiving care and treatment. (2) (b) Care and treatment must be provided in a safe way for service users doing all that is reasonably practicable to mitigate any such risks. **How the regulation was not being met:** • There was no on-call gastrointestinal bleed rota to protect patients from preventable harm. • Staff did not respond appropriately in administering treatment in the recommended time frame in accordance to the sepsis six bundle of care.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

(2) (a) Care and treatment must be provided in a safe way for service users by assessing the risk to the health and safety of service users of receiving care and treatment.

How the regulation was not being met:

- Ligature risk assessments had not been undertaken in all required areas.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014: Good Governance 17 (2) (c) Systems or processes must be established and operated effectively to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and for decisions taken in relation to the care and treatment provided. **How the regulation was not being met:** • There were a significant number of omitted medication doses with no reasons recorded on the medication record. These included critical medicines such as anticoagulants, antibiotics and anti-epileptic medicines.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1) (f) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014: Premises and equipment

This section is primarily information for the provider

Requirement notices

15(1) (d) Properly maintained- Suitable arrangements for the service for the purchase, service, maintenance, renewal and replacement of premises and equipment.

How the regulation was not being met:

There was no procedure in place for checking the emergency buzzers in the outpatient departments. Departments did not routinely check emergency buzzers.

15 (1) (f) All premises and equipment must be appropriately located for the purpose for which they are being used.

How the regulation was not being met:

- Ligature cutters were not accessible and available when needed to meet the needs of people using the service.

15 (2) The provider must, in relation to premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.

How the regulation was not being met:

- There were dusty areas in the resuscitation area were dusty.
- The fridge in the patients' kitchen had a sticky substance on one of the shelves, the work surfaces were stained and surgical tape which was visibly dirty had been used to secure a notice.
- Monthly cleaning audits did not consistently meet the trusts target.
- Daily cleaning checklist were not consistently completed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014: Staffing 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- The trust was not adhering to national guidelines in respect of the number of staff required to care for patients requiring non-invasive ventilation (NIV) due to low staff numbers and increased use of agency and bank nurses.
- Medical staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times.
- Not all staff had the training and completed competences recommended by the trust to care for patients with a tracheostomy or who were receiving non-invasive ventilation.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 4 A (a) and part 4 A (b) of the Health and Social Care Act 2008 (Registrations) Regulations 2014: Notification of other incidents 4 A The registered person must notify the Commission which occur whilst services are being provided in the carrying out of a regulated activity. (a) Any request to a supervisory body made pursuant to Part 4 of Schedule A1 to the 2005 Act by the registered person for standard authorisation: (b) Any application made to a court in relation to depriving a service user of their liberty pursuant to section 16(2)(a) of the 2005 Act. **How the regulation was not being met:** The trust had not informed the Care Quality Commission (CQC) about any Deprivation of Liberty Safeguards (DoLS) applications between September 2015 and September 2016.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 **Regulation 18 (1)** Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. **How the regulation was not being met:** • Medical staffing in the children's and young people's service did not meet the Royal College of Paediatrics and Child Health (RCPCH) standards for sufficient paediatric consultants and paediatric consultant availability for peak times, seven days a week. • Nurse staffing on the children's ward did not meet the RCN (2013) staffing guidance where a band six experienced paediatric nurse was available on shift throughout the 24 hour period. • Training shortfalls existed in Advanced Paediatric Life Support (APLS) and European Paediatric Life Support (EPLS) training. This meant the service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the Royal College of Nursing (RCN) 2013 staffing guidance.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 **Regulation 12 (2)(a)** Care and treatment must be provided in a safe way for service users by assessing the risk to the health and safety of service users of receiving care and treatment. **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

- Where patients had met the trust's criteria for sepsis screening, not all patients were screened in accordance with national guidance.

Regulation 12 (2) (d)

Care and treatment must be provided in a safe way for service users by ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

How the regulation was not being met:

- The children's ward had not completed a ligature risk assessment, despite admitting children and young people with mental health issues such as suicide ideation and self-harm.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance HSCA 2008 (RA) Regulations 2014 Regulation 17: Good Governance (1)Systems or processes must be established and operated effectively to ensure compliance with the requirement in this Part. (2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. **How the regulation was not being met:** As of the week of the inspection, there were 8,108 patient appointment outcomes, not correctly recorded on the electronic record system. We saw the availability, the condition and storage of medical records presented risks to confidentiality and ongoing care and treatment.

This section is primarily information for the provider

Requirement notices

As of 11th October 2016, 1,805 new referrals had not been graded as to their degree of urgency for treatment or investigation.

An initial 1,119 patients who are waiting for an appointment are not on the waiting list.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance HSCA 2008 (RA) Regulations 2014 Regulation 17: Good Governance. 17(2) (a) Systems and processes must be established and operated effectively to ensure the registered person assess, monitor and improve the quality of services provided in the carrying on of the regulated activity. **How the regulation was not being met:** Failing to meet incomplete referral to treatment national standard for three consecutive months. Failing to meet the majority of the cancer waiting targets Jan 2016 to September 2016.