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	Requires improvement
Accident and emergency	Good
Medical care	Requires improvement
Surgery	Requires improvement
Maternity and family planning	Good
Services for children and young people	Good
End of life care	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the Pilgrim Hospital on 1 and 2 May 2014 as part of the wider inspection of United Lincolnshire Hospitals NHS Trust. The trust was chosen for inspection because it was an example of a 'high risk' trust. Sir Bruce Keogh's review (Keogh Mortality Review) in 2013 found significant concerns, and the trust was placed in 'special measures' as a result. We returned in February 2015, and found that significant improvements had been made to services. We had some concerns raised in the year about maxillofacial surgery and cardiology services, and we reviewed these concerns as part of our inspection. We planned to inspect only the areas which were found to require improvements at our previous inspection; however during our inspection we noted some poor practice in the medical service. We have therefore reviewed the previous ratings in effective and caring key questions.

In May 2014, we found that the hospital was rated as requiring improvement. Core services for accident and emergency (A&E), medical care, surgery and maternity were found, overall, to require improvement. We returned in February 2015, and found that services in the accident and emergency and maternity services had improved. However surgery and medicine still had some improvements to make. We found that a lack of privacy and dignity, the poor management of pain and access to fluids meant that the rating was moved from good to requires improvement. Overall the hospital still requires some improvement to ensure that all patients receive good care.

Our key findings from our February 2015 inspection were as follows:

- There was significant improvement in clinical staff engagement, with senior clinicians sitting on the Clinical Executive Committee making decisions, and reporting directly to the trust board.
- Staffing levels had improved, although there were still some vacancies, which the hospital was aware of and had plans in place to address.
- There was limited high dependency provision for children within the hospital; however, the hospital is not commissioned for this type of provision. Action had been taken to address our concerns, and one room was available for this type of care whilst awaiting transfer.
- Care and treatment were delivered in line with national guidance and best practice.
- Throughout the hospital, staff were said to be caring, kind and compassionate.
- Patients' privacy and dignity was respected and maintained. Patients and their relatives were complimentary about care, and results from the NHS Friends and Family Tests were positive.
- Improvements are still required in meeting the four hour waiting time target in A&E.
- Over 600 operations in the hospital were cancelled over the last year, mostly because there were no beds available. Data from NHS England for February 2014 showed that general surgery and orthopaedics were missing their 90% referral to treatment time targets.
- Improvements had been made to the maternity unit, and whilst the building was still in the process of being refurbished, access to specialist midwives had improved.
- Access to mental health services had improved.
- The visibility of the senior leadership of the trust, with executive members working at the hospital weekly, had continued, and was appreciated by staff we spoke with.
- Infection control within the hospital was good, overall. Departments and wards were seen to be clean, with hand-washing facilities, alcohol gel and personal protective equipment (aprons and gloves) available. Staff were seen to be conforming to the 'bare below the elbows' policy, and washing their hands between patients.

We saw several areas of outstanding practice, including:

- The involvement of a former patient, who had previously complained about their care and treatment, in the recruitment process for new staff in the Patient Liaison and Advice Service (PALS) team.

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

Summary of findings

Importantly, the trust must:

- Ensure that all patients are treated with dignity and respect, and that care meets their individual needs, especially those patients who may have a lack or diminished capacity.

In addition the trust should:

- Review pathways for paediatric patients to receive treatment that meets their needs, and is in line with current guidance in respect of cystic fibrosis and cerebral palsy.
- Review mechanisms for ensuring that documentation reflects patients nutritional and hydration intake.
- Take steps to inform patients of the key quality initiatives in maternity services.
- Continue to take steps to address performance times, in respect of patients getting timely treatment in surgery.
- Continue to review the risks associated with children requiring a higher level of care, to ensure their safety.
- The hospital does not meet the minimum number of operators for a sustainable pacing service according to national guidelines from Heart Rhythm UK. The trust needs to address the concerns of the local operator and should ensure this service device meets the minimum standard required for such a service as specified in national guidance. The Trust suspended service on this site in November 2014 due to concerns raised and will recommence when Heart Rhythm UK standards can be met.

Following this focused inspection and in light of the significant improvements made overall by the trust I have recommended that the trust is removed from 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?
Accident and emergency	Good 	In 2014 we found that the safety in the department required improvement. There were not sufficient staff employed by the trust to meet people's needs. There were not always paediatric nursing staff on duty to provide care to children and young adults. There were only three consultants working in the department, two of whom were locums. This meant that they had to cover the department on a one in three rota, which they said was difficult. When we returned to inspect the emergency department at Pilgrim Hospital on 3 February 2015, we found that the staffing levels had improved to a safe level, which included paediatric nurses. The level of consultants had improved, although there were still consultant vacancies. In 2014 we found that there was a reliance on agency nurses and healthcare assistants, with over 40% of the staffing being provided in this way. We saw in February 2015 that the reliance on agency nurses had drastically reduced. In 2014, there were not sufficient numbers of infusion pumps available to ensure fluids and blood were administered using this equipment. In 2015 the trust had invested in equipment, and we found the availability of infusion pumps across the emergency department had increased. The department was clean, and staff were seen to wash their hands and use alcohol gel, where appropriate. Staff were aware of clinical guidance for patients with specific needs or diseases. Assessment of pain was undertaken as part of the admission process, and dealt with effectively. Staff in the department were caring and compassionate. Patients' privacy and dignity was maintained, and they were treated with respect. Call-bells were within reach for patients to call for assistance. In 2014 we found that the department was not always responsive to patients' needs. Improvements were required in meeting the four hour waiting time target. There was a lack of focus on equality and diversity given the number of non-English speaking people living in the local community. Signage was

Summary of findings

only in English. In addition, support for people with a learning disability was not always available. During our inspection on 3 February 2015, we found that the department was responsive to patients' needs, and improvements had been made with taking handover of patients care from the ambulance service in a timely manner. We saw that the department had worked hard to improve seeing patients within the four hour target. We saw a good level of service to support patients whose English was not their first language, with clear signage and telephone translation services.
The department was well-led. The emergency department had strong leadership at local and middle management levels, with staff feeling very supported in their roles. Staff felt confident to take any concerns to their line manager, as they felt that they would be dealt with. New members of staff, including students, had a good induction to the units and felt supported.

Medical care — **Requires improvement** 

At our inspection in 2014, safety and responsiveness in the medical care service required improvement. Staff had not received appropriate training to operate intravenous infusion pumps. Also, it was not possible to establish whether staff had completed training, because records were not up to date or accurate. There were not sufficient nursing or medical staff, particularly in the evenings and at weekends. We found that whilst the trust had systems in place to discharge patients in a timely manner, this had yet to be embedded so that the flow of patients was improved.
There were good systems for reporting and learning from incidents. Staff were following identifying needs and risks, and taking appropriate action to manage these. However, we found that whilst good practice was taking place in relation to stroke care, this was not shared across the trust. Staff were found to be caring and compassionate. Patients and relatives were highly complimentary about the care they received and the attitudes of staff.
In February 2015, the trust's safe nursing staff levels were being supported by the regular use of bank and agency nurses in many areas, despite on-going recruitment. Staff received feedback from any serious incidents they raised, and lessons were

Summary of findings

learned. Medicines management was effective, and staff were using the sepsis care bundle appropriately. Additional electronic profiling beds and infusion pumps had been purchased, and mandatory training levels had improved. However, there was a lack of facilities for providing cardiac monitoring on general medical wards, which could pose a risk to patients. Completion of fluid charts was variable, and patients did not always have access to, or were supported appropriately to take, fluids and nutrition. On the medical admissions unit we saw examples of poor care and lack of dignity. Elsewhere we saw examples of exceptional care, especially for cardiology patients.
The discharge lounge was not always utilised effectively, and care of the elderly wards were not using specific care plans for those patients living with a dementia, nor using the trust's own booklet to gain a better understanding of a patient's individual needs. The strategy for cardiology services at the hospital had yet to be finalised, and nursing staff were unclear on the future of the service. The executive team were visiting the hospital frequently, and lessons were being shared within the medical directorate across the trust.
Regular morbidity and mortality reviews were undertaken and Cardiology reviews were discussed as part of Medicine Specialty Governance, although the local management team was unaware about difficulties in the cardiology service at the hospital. Staff felt better able to raise concerns without fear of reprisals.

Surgery **Requires improvement**

While surgical areas were clean, there were some areas for improvement in the safety of the service, with respect to the recording of care, which could have an impact upon the safety and welfare of patients. In 2014, records relating to VTE and catheter care were not always completed. These were areas in which the trust has had higher levels of incidence and infection than expected. In 2015, we saw that the Safety Thermometer reflected inconsistency in completion of records across the surgical wards for falls, catheter care and some VTE assessments. We found that one ward was very cluttered in corridors, and also the medicines room, which impeded access to other equipment. In 2014

Summary of findings

on one ward, we saw evidence of a high level of error in the prescribing of medicines. This put patients at risk of receiving incorrect medication. In 2015 we saw that this had been rectified.
The service provided effective and evidence-based care and treatment. There were excellent audit results for patients treated for fractured neck of femur, and theatres operated to best practice guidance. Enhanced recovery protocols were in place for some colorectal and vascular surgery.
Staff were seen to be caring and compassionate while delivering care. Patients' privacy and dignity was maintained. Patients we spoke with were positive about the care and attention they had received while they were inpatients. Surgical wards scored highly in the NHS Friends and Family Test.
Services were responsive to people's individual needs. However, there were issues regarding capacity and flow in the service. There were over 600 cancelled operations for the hospital for the last year, with the majority being because there were no beds available. In 2014 data from NHS England for February 2014 showed that general surgery and orthopaedics were missing their 90% referral to treatment time target. In 2015, we saw that the treatment times for surgeries carried out at Pilgrim Hospital were still not meeting treatment time targets. Senior medical staff were concerned about the number of high dependency unit (HDU) beds, particularly as all patients with epidural analgesia required one.
The service was well-led. Staff reported that there had been significant positive change in the last year, and felt that at directorate and ward-level, they were moving in a clear direction. We spoke with staff, who were proud of the quality of care they provided, and were clear of their department and hospital's values.

Maternity and family planning

Good

In 2014 the trust had reported two similar 'never events' within 12 months. Action taken following the first 'never event' had not been embedded into practice, monitored and reviewed to prevent recurrence of an unacceptable event. In 2015, we found ongoing safety improvements in the maternity unit at Pilgrim Hospital. The risk management and incident reporting practices had been developed since the last inspection in May 2014. The risk

Summary of findings

system was more robust, and communication around risks was improving across the trust, as well as the directorate, to ensure lessons were learnt and practice changes embedded.

In 2014 significant environment risks had been identified, but no substantial risk control had been put into place at the time of our inspection. In 2015, the trust were taking appropriate steps to address the key concerns. The trust had previously identified the presence of asbestos in the maternity building as an environmental risk, and had introduced substantial risk controls since our previous inspection in May 2014. The Health and Safety Executive were in the process of approving and closing the improvement notices, as the trust were showing that adequate risk controls, regarding the presence of asbestos, were now in place.

Clinical effectiveness was embedded in practice, and all policy and standards were evidence and research-based. The provider had robust systems in place for the ratification of new policies and guidance. We saw improvements in the maternity dashboard, which represented how national indicators were measured to show the responsiveness of the unit; however, it was not clear how patients were informed of these indicators.

All the women we spoke with told us that they were happy with their care, and were involved in the planning of their care and treatment.

In 2014, there were no specialist midwives for bereavement, substance misuse, or safeguarding. At our inspection in February 2015, we found that funding for a substance misuse specialist midwife has been requested as part of CQUIN for 15/16, and there is further consideration for developing the specialist midwife roles across the trust, which is noted as work in progress.

In 2014 we found that there were no facilities available for women with low risk pregnancies and labours to have their babies in a midwifery-led unit, or to access a water birth, though these facilities are under construction. In 2015, we found that improvements have been made to review and develop maternity services at Pilgrim Hospital, such

as the introduction of a new maternity unit, which is due to open in October 2015, and the provision of a birthing pool to provide women with more choice at time of delivery.
In 2014 we found that there was no formalised system in place to ensure that the head of midwifery post was temporarily covered until a replacement head of midwifery could be employed. In 2015 we found that a new head of midwifery (HOM) had been appointed across the trust in August 2014. Staff were positive regarding the current leadership, and the strong focus on governance, staffing and risk management since this appointment. In response to the previous inspection findings in May 2014, the maternity unit was currently reviewing work planning, clinical performance and governance score cards, in line with national guidelines to develop the measures for safe practice.

Services for children and young people

Good

There was no dedicated high dependency unit (HDU) provision. The staff we spoke with told us that this meant that children with complex requirements were often nursed on the general paediatric ward. In 2015, the service had implemented an acuity tool to monitor the dependency of patients within the service. This information was being used to ascertain the number of staff required on a shift, and was also being shared with the clinical commissioning group (CCG).
In 2014 we found that there was no access to the child and adolescent mental health service for those children and young people who required specialist mental health support. In 2015, we found that improvements had been made to ensure child and adolescent mental health services (CAMHS) could be accessed 24 hours a day and seven days a week. The service had also secured four self-harm nurses, two of which supported Lincoln County Hospital. These nurses could respond within two hours of being contacted.
In 2014 we found that on a significant number of shifts, the staffing levels fell below the recommended levels. In 2015, we found that the service had taken steps to mitigate the risks of unsafe staffing levels by closing beds, but was still not meeting the staffing recommendations issued by the Royal College of Nursing (RCN).

Summary of findings

In 2014 we found that beds and cots were stored in the corridors, which made the environment cluttered and a risk to the patients using the service. In 2015, we saw that a room had been dedicated to the storage of such equipment.

End of life care

Good

The service was safe. There was a good culture of reporting and learning from incidents. Records were in place, documenting patients' wishes regarding resuscitation that were appropriate. Some records did not always document the involvement of relatives in the decision-making process.
The service was effective, working to the Gold Standard Framework. Patients' pain relief was prescribed and administered in a timely manner. The trust had taken part in the National Care of the Dying Audit, the results of which were awaited at the time of our inspection.
The service was caring. Patients received care from staff that was attentive and sensitive to their needs. Patients and the families we spoke with were positive about the care they received. Patients' privacy and dignity was maintained.
The service was responsive to patients' individual needs. In 2014 staff told us that end of life care services were planned on the principle of person-centred care. This meant that patients' wishes were at the centre of decisions made about their care. However, in 2014, only 17.5% of patients who died in the hospital were seen by the palliative care team. Staff reported a high demand for support from the palliative care team, which they were not able to provide. We were told that the trust was going to address this through the recruitment of an additional palliative care nurse. In 2015, we found that the trust had implemented link nurses on each ward, who identified patients at the end of their life.
The service was well-led. We found that staff shared the visions and values of the trust; namely, that the patients were at the centre of decisions made about how the service was run. The views of patients and staff were being proactively sought to drive up standards in the service.

Requires improvement

Pilgrim Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Maternity and family planning; Services for children and young people; End of life care;

Contents

Detailed findings

Background to Pilgrim Hospital

The Pilgrim Hospital, Boston, is a medium-sized hospital with 350 beds. It is part of United Lincolnshire Hospitals NHS Trust, formed in April 2000 by the merger of three acute hospital trusts in Lincolnshire. The trust is one of the largest in the country. The trust, as a whole, provides services to a population of 700,000 people in Lincolnshire.

The hospital provides services that include: 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.

We inspected the service in 2014 because the trust had been placed in special measures following the Keogh Mortality Review in 2013. The trust was seen as high risk in our Intelligent Monitoring system. We recommended that the trust was kept in special measures for a further six months. We re-inspected the service in February 2015.

Our inspection team

Our inspection team in 2014 was led by:

Chair: Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission (CQC)

Head of Hospital Inspections: Fiona Allinson, Head of Hospital Inspection, CQC

In 2015 our inspection team was led by:

Chair: Gillian Hooper, Improvement Director, Monitor

Head of Hospital Inspections: Fiona Allinson, Head of Hospital Inspection, CQC

The team of 33 included 11 CQC inspectors and two pharmacist inspectors, an oral and maxillofacial surgeon, a consultant in medicine, a cardiology consultant, a head of clinical services and quality, a senior theatre practitioner, a district nursing sister, a senior midwife and a senior paediatric nurse, and an 'expert by experience'. (Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services.)

How we carried out this inspection

To get to the heart of the 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 visiting, we reviewed a range of information and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), NHS Trust Development Authority, NHS England, and the local Healthwatch.

In April 2014 we held three listening events in Lincoln, Boston and Grantham on 29 April and 30 April 2014, where people came to share their views and experiences of the trust. Some people who were unable to attend the listening events shared their experiences via email or telephone. At this inspection in February 2015, we did not hold a listening event, but spoke directly with patients and relatives at all hospitals.

We carried out an announced inspection visit from 2 February to 4 February 2015, with an unannounced inspection on 1 February 2015 at the Lincoln and Boston sites. We spoke with staff individually, as requested.

Detailed findings

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at United Lincolnshire Hospitals NHS Trust.

Facts and data about Pilgrim Hospital

Key facts and figures about the trust

Lincoln County Hospital: 601 beds

Grantham and District Hospital: 115 beds

The Pilgrim Hospital: 350 beds

Inpatient admissions: 152,760 2013/14

Outpatient attendances: 674,856 2013/14

A+E attendances: 144,239 2013/14

Births: 6,525

Deaths

Annual turnover

Surplus (deficit): £0.1m deficit

Intelligent Monitoring

- Safe: Risks = 1, Elevated = 0, Score = 1
- Effective: Risks = 1, Elevated = 1, Score = 2
- Caring: Risks = 1, Elevated = 0, Score = 1
- Responsive: Risks = 1, Elevated = 1, Score = 2
- Well led: Risks = 6, Elevated = 2, Score = 8
- **Total:** Risks = 10, Elevated = 4, Score = 14

Individual Elevated Risks

- All cancers: 62 day wait for first treatment from urgent GP referral
- TDA - Escalation score
- Whistleblowing alerts

Individual Risks

- Proportion of patients risk assessed for Venous Thromboembolism (VTE)
- Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures
- Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?"
- The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason
- Data quality of trust returns to the HSCIC
- NHS Staff Survey - KF7. % staff appraised in last 12 months
- NHS Staff Survey - KF9. support from immediate managers
- NHS Staff Survey - KF21. % reporting good communication between senior management and staff
- Composite risk rating of ESR items relating to staff sickness rates
- Composite risk rating of ESR items relating to staff support/ supervision

Indicators By Domain

Safe:

- Never events in past year 2
- Serious incidents (STEIs) 173 Serious Incidents occurred at the trust
- Proportion of patients risk assessed for Venous Thromboembolism (VTE) one risk
- National reporting and learning system (NRLS)
- Deaths 20
- Serious 128
- Moderate 870
- Abuse 42
- **Total 1,060**

Effective:

- HSMR Within expected range
- SHMI Within expected range

Caring:

- Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?" one risk

Responsive:

- Bed occupancy 79.6%

Detailed findings

- All cancers: 62 day wait for first treatment from urgent GP referral one elevated risk
- The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason one risk
- Delayed discharges: No evidence of risk
- 18 week RTT: No evidence of risk
- Cancer wards: No evidence of risk

Well-led:

- Staff survey: **below average**
- Sickness rate: 5.2 % **above**
- GMC training survey: **below average**
- Data quality of trust returns to the HSCIC one risk
- TDA - Escalation score one elevated risk
- NHS Staff Survey - KF7. % staff appraised in last 12 months one risk
- NHS Staff Survey - KF9. support from immediate managers one risk
- NHS Staff Survey - KF21. % reporting good communication between senior management and staff one risk
- Composite risk rating of ESR items relating to staff sickness rates one risk
- Composite risk rating of ESR items relating to staff support/ supervision one risk
- Whistleblowing alert one elevated risk

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Accident and emergency

Accident and emergency

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

Information about the service

The emergency department within Pilgrim Hospital includes A&E as well as the clinical decisions unit (CDU) and ambulatory emergency care (AEC). CDU admitted mainly medical patients from both A&E as well as GPs. During our inspection, we spoke to approximately 12 patients and relatives to obtain their feedback on the care they were receiving. The AEC had been open since October 2013, diagnosing and treating patients on the same day, using a multidisciplinary, consultant-led team. It received a trust award for improving patient services earlier in 2014.

The out-of-hours service for patients not needing A&E services was operated by Lincolnshire Community Health Services and works from the same building, adjacent to A&E. We were informed the patient pathway to the out-of-hours service needed a more integrated approach to enable it to be more effective. Other organisations were helping to achieve this.

The emergency department saw 49,500 patients in 2013/2014. In 2003/2004 it saw 35,000; an increase of 29% in ten years.

When we returned to inspect the emergency department on 3 February 2015, we spoke with four members of the nursing team, three senior nurses, and two members of the medical team. We spoke with three patients and observed care being delivered.

Summary of findings

In 2014 we found that the safety in the department required improvement. There were not sufficient staff employed by the trust to meet people's needs. There were not always paediatric nursing staff on duty to provide care to children and young adults. There were only three consultants working in the department, two of whom were locums. This meant that they had to cover the department on a one in three rota, which they said was difficult. When we returned to inspect the emergency department at Pilgrim Hospital on 3 February 2015, we found that the staffing levels had improved to a safe level, which included paediatric nurses. The level of consultants had improved, although there were still consultant vacancies. In 2014 we found that there was a reliance on agency nurses and healthcare assistants, with over 40% of the staffing being provided in this way. We saw in February 2015 that the reliance on agency nurses had drastically reduced. In 2014 there were not sufficient numbers of infusion pumps available to ensure fluids and blood were administered using this equipment. In 2015, the trust had invested in equipment, and we found the availability of infusion pumps across the emergency department had increased.

The department was clean, and staff were seen to wash their hands and use alcohol gel, where appropriate.

Accident and emergency

Staff were aware of clinical guidance for patients with specific needs or diseases. Assessment of pain was undertaken as part of the admission process and dealt with effectively.

Staff in the department were caring and compassionate. Patients' privacy and dignity was maintained, and they were treated with respect. Call-bells were within reach for patients to call for assistance.

In 2014 we found that the department was not always responsive to patients' needs. Improvements were required in meeting the four hour waiting time target. There was a lack of focus on equality and diversity given the number of non-English speaking people living in the local community. Signage was only in English. In addition, support for people with a learning disability was not always available. During our inspection on 3 February 2015, we found that the department was responsive to patients' needs, and improvements had been made with taking handover of patients care from the ambulance service in a timely manner. We saw that the department had worked hard to improve seeing patients within the four hour target. We saw a good level of service to support patients whose English was not their first language, with clear signage and telephone translation services.

The department was well-led. The emergency department had strong leadership at local and middle management levels, with staff feeling very supported in their roles. Staff felt confident to take any concerns to their line manager, as they felt that they would be dealt with. New members of staff, including students, had a good induction to the units and felt supported.

Are accident and emergency services safe?

Good

All units making up the emergency department were seen to be clean and tidy. A&E had improved the speed of turnaround of patients, ensuring that they received a safer, more effective assessment of their condition on arrival. Equipment was checked regularly, and staff were seen using appropriate alcohol gel or washing their hands between patients. Staff across the emergency department had systems in place to manage deteriorating and very sick patients.

There were either processes in place or being set up to ensure that all staff learned from any patient-related incidents occurring in the department. Although A&E did not have a system for monitoring any potential harm to patients, there were plans in place to introduce one. In 2014 the medication storage and preparation area in A&E had no clear, clean surfaces to draw up intravenous medication for administering to patients; plans were in place to rectify this. We saw in February 2015 that the medication storage and preparation area had been redesigned, with the implementation of new storage cupboards that supported good infection prevention and control practice, and there was space identified for drug preparation. In 2014 we found that there were a lack of infusion pumps to ensure safe and controlled delivery of medicines and fluids to patients. In 2015 we found that the trust had invested in equipment, and that this was no longer an issue. Also in 2014, we found that there was a lack of permanent nursing and medical staff in A&E. As a result, agency nursing and locum medical staff were used on a regular basis. However, at our inspection in February 2015, we found that nurse staffing levels had improved, although there were still some consultant vacancies at the trust.

Incidents

- In the 12 months prior to inspection in 2014, the emergency department, including A&E, the CDU, and emergency admissions centre (AEC), reported a total of 312 incidents relating to non-clinical incidents, patient safety incidents, and those that impacted on staff. A&E had the highest number of non-clinical incidents,

amounting to 14 in total. Ten of those related to staffing, facilities or the environment. CDU raised the highest number of patient safety incidents. Seventy of those related to accidents that could result in personal injury.

- Staff told us that they had used the incident reporting system to report, for example, low staffing levels with possible patient safety issues. They told us that they did not receive feedback about the outcomes of these. However, there was a new structure in place, and any issues in the future would be fed back at staff meetings.
- In February 2015 we spoke with four members of staff, who told us that they now receive feedback from incidents and complaints, and that the system has been made easy to use, with permitted time to complete incident reports.
- The matron of the department informed us that monthly mortality meetings were held to discuss issues arising and lessons learned from any deaths in the department.
- The trust was rated 'low risk' for access to secondary care through A&E; this data was received from the CQC analysis of secondary care, September 2012 to January 2013.
- In 2014 there was one area where the trust was shown to be worse than other trusts. This area related to the time it took patients to get into A&E from an ambulance. During our inspection in February 2015, we spoke with three ambulance crews, who told us that there was no longer a problem with the transition from the ambulance to the emergency department. We observed 13 ambulances arrive at Pilgrim Hospital emergency department between 11am and 1.30pm, and all ambulance arrivals were completed in a timely manner with no problems.

Safety Thermometer

- The safety quality dashboard was not in use in A&E in 2014.
- In 2014, the matron of the department informed us that they had commenced work on producing a safety and quality dashboard specifically for the A&E department. We saw in our inspection in February 2015 that the emergency department matron had completed audits within the department, such as department performance, compliance with infection prevention control and how long people waited to be seen. The first quality dashboard information was due to become available in the next few weeks, and will be displayed for both patients and staff.

Cleanliness, infection control and hygiene

- A&E, CDU and AEC were seen to be clean and tidy. Domestic waste, clinical waste and sharps bins were filled to an appropriate level and not over-filled.
- During our inspection, we observed good personal protective equipment practice in A&E, CDU and AEC.
- We saw hand gel dispensers in place in each department. They were easily accessible. Staff were seen using the gel or washing their hands between patients.
- In A&E we saw the resuscitation trolley. It was clearly labelled, stating the date and time it had been cleaned: '8:10am on 2 May 2014', which was one hour before we saw it.
- Patients were routinely screened for MRSA when admitted to the ward areas, for example CDU and for Clostridium difficile (C. difficile) when appropriate. There had been one case of C. difficile in CDU over the year prior to our inspection and no cases of MRSA. A&E had one case of MRSA in the same period.
- When we spoke with the matron for A&E in 2014, they informed us that their last audit (check) for cleanliness in the department had attained 88%. They told us that they had recently increased the number of cleaning staff during the morning to ensure cleanliness was maintained. We saw in February 2015 that this was now in place, and that cleanliness throughout the department had improved.

Environment and equipment

- The areas around beds in CDU had sufficient space to enable mobile equipment to be placed around them.
- Some of the cubicles in A&E were small, with limited space, although cubicles used for assessing new patients, and the resuscitation areas, were of a good size.
- Staff told us that patients could be moved into larger cubicles if it became necessary.
- Because of a newly organised rapid assessment area in A&E, this had improved the speed of turnaround of patients, ensuring they received a safer, more effective assessment of their condition on arrival.
- In 2014 we saw that the medication storage and preparation area in A&E had no clear, clean surfaces to

draw up intravenous medication for administering to patients. The department had acknowledged this and had plans in place to rectify it, but had made no final sign-off or start date for the work to be done.

- We saw during our inspection in February 2015 that the trust had completed the work required in the medication storage and preparation room. New storage cupboards had been installed which had a clear front that limited the amount of times that it had to be opened, as staff were able to see the stock and levels. There was a clear work area that was clearly identified for the preparation of medication. We observed a nurse carry out a drug preparation following trust protocol.
- All medicines and intravenous fluids were stored securely and appropriately in all areas.
- In 2014 staff in the resuscitation area of A&E and in CDU, informed us that there were not enough infusion pumps available in the areas. Infusion pumps are used to deliver medicines and fluids into a patient's body at a precisely controlled rate. We were informed this had been flagged up to senior management in the trust, although we did not see this on the trust risk register dated February 2014.
- In February 2015 we saw that the trust had invested in equipment and in particular infusion pumps. We saw that each resuscitation bay had its own supply of infusion pumps, and further infusion pumps were available across the emergency department.
- Equipment was checked on a regular basis, including equipment used for resuscitation.
- Lack of electric beds for patients was something staff informed us about, in 2014, on CDU and AEC. We did not see evidence of this being listed on the trust risk register in February 2014. Information we received from the trust, revealed that 12 standard non-electric beds were in place on CDU. During our inspection in February 2015, we saw that patients were on electric profile beds, and there was adequate availability of specifically designed emergency department trolleys.

Medicines

- Medicines were stored, managed, checked and administered well in A&E and CDU.
- We saw that checks were undertaken for controlled drugs twice a day, following a recent error in A&E. We checked them against the controlled drugs log and found them to be correct. Controlled drugs in CDU were also correct.
- When we spoke with one patient in 2014, in a cubicle in A&E, we saw they had brought their medicines into the department with them. These were not stored securely, and had been placed on a chair in the cubicle with them, and were clearly visible to anyone walking past. In February 2015, we saw that the emergency department had adopted a safe procedure with the management of medication brought in by patients attending the emergency department. We saw that patient's medication was placed into pharmacy bags clearly identified, and the patients name was added onto the bag. The bag then travelled with the patient. We observed this in practice.

Records

- We spoke with staff in A&E about how they ensured that information was given to other staff in the hospital when transferring patients to wards. They told us that they photocopied the A&E pro forma to take with patients, so the receiving ward had all the information required for patients to receive good continuity of care.
- In 2014 we heard from staff in CDU and AEC that the handover process for a patient from A&E was sometimes a concern. There was no confirmation of the verbal handover documented anywhere. At our inspection in February 2015, we saw that handovers were comprehensive.
- Original documents, such as electrocardiograph (ECG) and 'track and trigger' sheets, were always sent with the patients to the receiving ward.
- Records in A&E included a full assessment of the patient, pressure area risk assessment, pain score, and medical notes.
- In 2014, we looked at patient records in CDU. They were clear, concise, and we saw bundles of care in place, such as sepsis, where appropriate.
- We saw one 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) form, in 2014, in place for a patient. It was appropriately completed, with discussions between relatives and patients documented clearly.
- In 2014 we looked at two medicine administration charts in CDU. They had been written legibly, and patients had received the doses of their medicines at the correct time. They had been signed by the person administering the medicines.
- Staff treating patients in A&E, who had attended the hospital previously, were able to access their records

quickly, 24 hours a day. However, the trust's risk register acknowledged that in 2007, despite previous efforts, the physical merge of all the trust's records had never been completed, so approximately 40,000 of 'current treatment' patients had multiple sets of records. This presented a clinical risk, as there was no complete health record available for such patients when they attended each site.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Patients we spoke with told us they were asked for their verbal consent before procedures were undertaken.
- Staff were aware of correct procedures if patients did not have the capacity to make an informed decision about their treatment or future care.
- The staff we spoke with in 2014 were not sure of when they had last received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. In February 2015, we spoke with two senior managers and three members of staff, who confirmed that they had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We looked at training records, which demonstrated to us that the compliance of training was 99%, with a trajectory of 100% completion by April 2015.
- Staff informed us a duty social worker was assigned to the A&E department and they had used the social worker to ensure mental capacity assessments had been undertake for patients when appropriate.

Safeguarding

- Although the trust was without a safeguarding lead for adults, we were aware one had been newly appointed and that a safeguarding practitioner was in post.
- The A&E department had two members of senior nursing staff who took the lead for safeguarding children. They had undertaken extended training in relation to this.
- The A&E department had, and we saw, the process for referring children to the relevant authorities who were at risk.
- A&E staff had access to a paediatric liaison nurse for referring children when they had left the department. This meant that any concerns could be followed up in the community.
- Staff we spoke with knew how to raise their concerns about adults and children who may be at risk.

Mandatory training

- Using the information the trust had sent us, we found by the end of March 2014 only 40% of the emergency department's staff had completed the trust's mandatory training. At our inspection in February 2015, we saw that compliance of core learning had improved and the compliance across the emergency department was 99%.

Management of deteriorating patients

- Patients in the waiting room in A&E were visible to reception staff at all times.
- We were informed that reception staff and the triage nurse observed patients in the waiting room during the course of their shift. If they were concerned about a patient, they would alert other staff.
- There was an escalation procedure in place for the hospital when lots of patients required treatment or when unplanned incidents occurred.
- We were informed this had been put into operation when Boston had been subject to flooding earlier in 2014 and when the x-ray department had caught fire. This had worked well.
- The A&E department is part of the East Midlands Major Trauma Centre. Any seriously injured patient would be transferred to Queen's Medical Centre in Nottingham for specialist care.
- A major accident policy was in place and an exercise to test its robustness in February 2014 had been successful.
- The track and trigger chart was used in all areas of the emergency department. This highlighted patients who were deteriorating.
- In 2014, we were informed that the national early warning system (NEWS) was due to be introduced. NEWS is a national early warning score system, and is believed to be more sensitive in use. At our inspection in February 2015, we saw that the emergency department had moved from the 'track and trigger' system, to the national early warning scoring (NEWS) system, and the paediatric early warning scoring (PEWS) system. (A national early warning score is a guide used to quickly determine the degree of illness of a patient. It is based on data from four physiological readings (systolic blood pressure, heart rate, respiratory rate, body temperature) and one observation (level of consciousness). The resulting observations are compared to a normal range to generate a single composite score).

Accident and emergency

Nursing staffing

- A nurse shift coordinator was responsible for allocating nurses to patients and ensuring the flow of patients into and out of the department was undertaken smoothly.
- In 2014, the trust did not have a full complement of its own nursing staff in A&E. We looked at three months of the previous 'off duty' rota from February to April 2014. We saw that bank and/or agency staff were used to support regular staff every day during that period. Matron informed us that up to 40% of nursing and support staff in A&E were agency or bank. We saw from the off duty rota that this was an accurate representation.
- In February 2015, we saw from rotas and speaking to managers that the use of agency staff had significantly reduced. We saw that the emergency department had reduced agency nurse use from 40% to 10%.
- It is acknowledged that some agency and bank staff had been used on a regular basis and therefore, knew the department and the processes and procedures well. In 2014, we spoke with one of them. They told us that they had worked in A&E as an agency band 5 staff nurse for two years.
- In 2014 vacancies in A&E comprised of one band 7, 3.6 band 6, and three band 5 staff members, against a whole time equivalent (WTE) of 35.5. In February 2015, the emergency department had a current nurse vacancy rate of 5.2 whole time equivalent (WTE); this had reduced from 7.6 that we had found in May 2014.
- The Royal College of Paediatrics and Child Health had set standards for children and young people in emergency care settings. These included the availability of a qualified children's nurse on each shift. This was not available in the hospital in 2014. We saw at our inspection in February 2015 that the emergency department had increased the paediatric provision; we saw two paediatric nurses on duty, and the department now has four dual trained qualified nurses in adults and paediatrics. We spoke with a band 5 qualified nurse, who told us that they had received training in paediatric immediate and advanced life support. All qualified nurses are trained in advanced paediatric life support, and unqualified nurses are trained in immediate paediatric life support.
- In 2014, the A&E was not using an acuity tool to determine staffing levels, such as the Baseline Emergency Staffing Tool (BEST). However, proposed staffing levels for the department had incorporated BEST guidance. During our inspection on 3 February 2015, we saw that the department had used the RCN 'BEST' acuity tool, and the whole time equivalent (WTE) of staff had increased after taking into consideration long-term sickness and transfers.

Medical staffing

- We were informed in 2014 by the A&E's only substantive medical consultant, that there had been great difficulty in recruiting permanent medical staff to the department. We saw an improvement at our inspection in February 2015, and two further consultants had commenced within the emergency department.
- Two other consultant posts were filled by locums in 2014, one of whom had been working in the department since 2006. The Department of Health guidance states that ideally, locums should not be employed for more than six months at a time. In February 2015, we saw that the department did use locum consultants. However, the locum consultants in use were consistent in the departments' practices, had received trust induction, and were highly respected amongst the department staff.
- At our inspection in 2014, a member of the nursing staff recalled a time, in the early hours of one morning, when it had been difficult to contact the consultant on-call. Procedures had been put in place that will prevent this happening again.
- An A&E consultant was usually in the department between 10am and 9pm, and on-call at night-time.
- The A&E department was supported by middle and junior grade doctors across the 24-hour period, although in 2014, there was no paediatrician (children's doctor) available in the department. When a paediatrician was required, a call was put out, and help was sent from the hospital's children's ward. In February 2015, we saw that there were two consultants with an interest in paediatric medicine, and the provision was safe, with support from the paediatricians within the children's services in the trust.
- The College of Emergency Medicine recommends that every emergency department should have a minimum of 10 WTE consultants in emergency medicine. This would allow a consultant to be present to supervise care for a minimum of 14 hours a day. This was not available in the hospital.

Accident and emergency

Are accident and emergency services effective?
(for example, treatment is effective)

Not sufficient evidence to rate

Staff were aware of clinical guidance for patients with specific needs or diseases. Assessment of pain was undertaken as part of the admission process and dealt with effectively. Care bundles, for example: fractured neck of femur, asthma and sepsis were in place and being used appropriately.

None of the medical staff had a paediatric qualification and only three nurses were trained to care for children. Paediatric specialist advice had to be obtained from the children's ward when required.

We did not re-inspect this aspect of the service in February 2015.

Evidence-based care and treatment

- We were informed the A&E department used National Institute for Health and Care Excellence (NICE) guidelines, where appropriate. For example, in the care and treatment of head injuries and strokes.
- Specific care bundles were available for the management of patients presenting with, for example, stroke, fractured neck of femur, asthma, sepsis and heart failure.
- Staff were aware of the one hour timeline required for scanning patients with a stroke. We did not see evidence that this had been achieved.

Pain relief

- An assessment of pain was undertaken on a patient's arrival in the hospital. Patients we spoke with in A&E and who informed us had been in pain, told us pain relief had been given very quickly on arrival in the department.
- We did not see any patients in pain in A&E, during our inspection.

Nutrition and hydration

- Patients in the A&E department for any length of time were offered sandwiches, biscuits and a drink when this was appropriate and safe to do so. No hot food was available.
- A drink machine was available in the waiting area for patients and relatives.

Competent staff

- We received information from the General Medical Council for 2013 that in the national training scheme survey they had received a comment related to A&E, which stated that junior doctors (foundation year one) were working above their competency level. It also stated that junior doctors were not receiving appropriate clinical supervision.
- Patients we spoke with did not feel this was the case; they felt confident in the doctors who were treating them.
- All the nursing staff we spoke with felt competent to undertake their role. Two of them informed us they would not undertake any tasks they did not feel able to do.
- Nursing staff were trained in basic life support and received regular updates. More senior staff received training in paediatric life support and/or advanced trauma nursing courses.
- The A&E department did not have a paediatrician (children's doctor) on duty at any time and only three qualified nurses were trained to care for children. Although there were systems in place to get support from the children's ward, this could mean that children did not receive care from appropriately qualified and skilled doctors and nurses quickly.

Multidisciplinary working

- Where appropriate, patients were transferred to different hospitals for specialist treatment. For example, Nottingham, Sheffield and Leicester.
- During our inspection, we were told about one patient who had been admitted to AEC inappropriately, as they were very sick and should have been nursed on a ward that would have better met their needs.

Seven-day services

- All areas of the emergency department were open seven days a week serving a large area of the Lincolnshire community living in the south west and coastal region of the county.

Accident and emergency

- Support services were also available, including, x-ray, scanning and pathology.

Are accident and emergency services caring?

Good

Patients felt they were listened to by health professionals and were cared for with compassion and kindness. Pain relieving medication was offered quickly when needed and call-bells were within reach for patients to call for assistance.

Staff were aware of the grieving process and knew how to treat relatives experiencing bereavement with dignity and respect. Systems and processes were in place to support this.

We did not re-inspect this aspect of the service in February 2015.

Compassionate care

- All the patients we spoke to across the different areas of the emergency department were complimentary of the care they had received.
- Two patients we spoke with during our listening events in Boston told us they were treated well in A&E and received prompt attention with dignity and respect.
- We saw examples of caring, professional interactions with patients. All patients had call bells within their reach and a drink available when it was safe for them to have one.
- We saw staff empathising with patients who were in pain and taking prompt action to rectify the problem.

Patient understanding and involvement

- Patients understood why they were in hospital. One person we spoke with told us they could not fault the care they had received and felt the doctor and nurses had been very kind and listened to what they had to say.

Emotional Support

- We spoke with staff about caring for relatives who had just lost their loved ones in A&E. We were shown a large picture of a butterfly that was placed on the cubicle door when a patient died. Staff told us when they saw the picture in use they tried to be very quiet in respect for the patient and their family members.
- A&E and CDU had a room specifically set aside for distressed relatives.
- We were informed relatives could stay as long as they wished to in the department after a patient's death, drinks were provided and patients were not moved until the relatives were ready.

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

Good

Waiting times in A&E between 5 August 2012 and 23 February 2014, across United Lincolnshire Hospitals NHS Trust, showed that the trust had struggled to maintain the 95% target for patients to be seen admitted, treated or discharged within four hours; and many times the trust has been below the England average. However, we saw that the admission process following transfer of a patient by ambulance into A&E worked quickly and smoothly.

There was a lack of focus on equality and diversity, given the number of non-English speaking people living in the local community. In 2014 signage was only in English. In addition, support for people with a learning disability was not always available. During our inspection in February 2015, we saw a good level of service improvement, to support patients whose English was not their first language, with clear signage and telephone translation services.

Service planning and delivery to meet the needs of local people

- A document was in circulation, entitled Future Health and Care Services in Lincolnshire, which involved all of the major stakeholders in Lincolnshire. It was considering the future provision of services across the county. We were told by nursing and medical staff in 2014 that this was having a negative impact on the service until the outcome was known. The senior A&E consultant informed us that this was particularly pertinent in recruiting medical personnel to the

department. In February 2015, we saw no change with regards to the document entitled Future Health and Care Services in Lincolnshire. However, the staff within the department were pro-active and driven to provide a good service, with a desire to fulfil the needs of people who use the services provided.

Access and flow

- Trusts in England are tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. Waiting times in A&E between 5 August 2012 and 23 February 2014, across United Lincolnshire Hospitals NHS Trust, showed that the trust had struggled to maintain the 95% target, and many times has been below the England average. Performance has improved, but they are still failing to maintain the 95% target. At our inspection in February 2015, the trust was showing as meeting the four hour target in only 83% of cases. However, we recognise that all of the trusts in the country are experiencing significant pressures during the period of our inspection.
- In 2014, the data showed that the percentage of patients leaving the trust's A&E departments before being seen meant that there was a lower than average amount of patients leaving up to one hour after arrival. This changed at the four hour mark, where it increased to 18.4%, then fell to be in line with the national average from the five hour mark to the 11 hour mark.
- In 2014, the percentage of patients that left A&E before being seen for treatment (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they have to wait) was similar to the England average. However, during 2014, the trust has reduced the number of patients leaving before being seen, and therefore it can be assumed that either patients are being seen in a more timely manner, or that they are happier to wait within the department.
- The trust performed better than the England average, apart from the month of July 2013, on the percentage of unplanned readmissions to A&E within seven days of a previous attendance at the A&E departments. In 2015 this figure continues to improve.
- In 2014 the percentage of patients still waiting in A&E after four hours was similar to the England average. From May 2014 to November 2014, there was a significant drop in the number of patients waiting between 4 to 12 hours following the decision to admit for treatment.
- We obtained data from East Midlands Ambulance Service (EMAS), relating to the length of time ambulance crews had to wait to hand patients over to A&E staff during the month of March 2014. This data showed that Pilgrim Hospital received 2,068 patients from EMAS during that month.
- When we inspected in 2014, we saw ambulances queuing with patients to hand over to A&E staff. We did not see ambulance waiting to hand over patients during our inspection in February 2015.
- NHS England requests trusts to measure the percentage of emergency admissions waiting four to 12 hours, from the decision to admit until patients are admitted. The trust was performing better than the England average for patients waiting four to 12 hours to be admitted to a ward. From May 2014 to November 2014 there was a significant drop in the number of patients waiting between 4- 12 hours following the decision to admit for treatment.
- While the national target is that all patients be admitted or discharged within four hours of arriving at A&E, it is important to see how long patients are waiting within this target time.
- The percentage of patients leaving the trust's A&E departments before being seen, showed that there was a lower than average amount of patients leaving up to one hour after arrival. This changed at the four hour mark, where it increased to 18.4%, then fell to be in line with the national average from the five hour mark to the 11 hour mark.
- In February 2015, we were told that the matron had introduced five acute care practitioners (ACP's) that enhanced the support to middle grade doctors. We saw that the ACP's managed the demand within the minor's treatment area, which allowed middle grade doctors to see patients in major treatment areas. This meant that clinical decisions were made sooner, and improved the patient flow through the department.

Accident and emergency

Meeting people's individual needs

- Boston had a high number of people in the community from Eastern Europe, in particular Poland. The hospital had access to translation services through the use of specialist telephones. Staff were aware of this and knew how to use them.
- Signs and notices in A&E were only written in English in 2014. We did not see any printed information for patients in any language other than English. In February 2015, we saw that the department had improved its signage. Each sign was translated into six different languages, including picture signage, from the demographics of the community that the emergency department served. These were displayed within and outside the department. We saw that the language line in use provided a translation service in eighteen different languages.
- Staff informed us that most patients either had a good knowledge of English or brought family members with them to aid translation.
- We did not speak with any patient who had a learning disability (LD). A&E staff informed us they had access to a specialist LD nurse, but they were not available at weekends. Staff also told us many people with a learning disability who attended the department were accompanied by someone who knew them very well and could aid communication, which they found very useful. However, they stated that they did not feel very supported on occasion.
- In 2014, there were no Makaton books in A&E for staff to use. Makaton is a language programme using signs and symbols to help people to communicate if they are unable to do so verbally.
- We spoke with three members of staff about their ability to help patients living with dementia when they needed to go to the department. They told us A&E cared for a lot of people living with dementia.
- One member of staff who had a special interest in dementia had received additional training to support them to give care to those patients. We spoke with that member of staff. They told us they enjoyed being able to give support in order to reduce the fear and anxiety patients may feel.
- The department could also ask for the community in-reach team to assist them for those patients if they required it. Two of the members of staff we spoke with told us they had not received training on dementia within the past twelve months. Dementia training was not on the training matrix for A&E.
- We did not speak with any patients who were experiencing mental health problems during our inspection. Staff we spoke with informed us of the process required when the department needed to refer patients to the mental health crisis team, which was provided by Lincolnshire Partnership NHS Foundation Trust (LPFT). They told us they contacted the crisis team from LPFT who must respond within four hours of the request, as part of the contract the trust had with LPFT to provide the service.
- When we spoke with staff about treating patients who were homeless, they told us they always ensured the patient had the ability to get to a shelter in Lincoln if it was required and they were not admitted. If admitted, they would get the support of social services. We were informed the trust would pay for the taxi to Lincoln if it was necessary.
- We were informed one of the chaplains employed by the trust was always on-call and could be in the department very quickly to give spiritual support when it was needed.

Are accident and emergency services well-led?

Good

The units forming the emergency department had strong leadership at local and middle management levels, with staff feeling very supported in their roles. The rapport between those staff groups appeared good. The matron of A&E was determined to ensure a regular and good liaison between all A&E departments across the trust, looking forward, to ensure important messages and good practice could be disseminated; this was something that had been lacking in the past.

Staff felt confident to take any concerns to their line manager and felt it would be dealt with. New members of staff, including students, had a good induction to the units and felt supported. An ex-patient who had made a complaint was being used in A&E as part of the recruitment process for a new member of staff. It had

proved to be an excellent experience for all. The focus on equality and diversity was difficult to see given the number of non-English speaking people living in the local community and the number of elderly patients attending with dementia.

We did not re-inspect this aspect of the service in February 2015.

Vision and strategy for this service

- Staff we spoke with knew of the visions and values of the trust. This included developing the staff and ensuring staff delivered a high quality service to patients.

Governance, risk management and quality measurement

- We asked staff if or how they would raise issues about safety concerns or poor practice in their department. The majority of staff told us they felt confident to take any concerns to their line manager and felt it would be dealt with.
- One member of staff gave us an example of how they had dealt with a situation and had felt empowered to take the situation to their manager and get it resolved.
- We saw the minutes from the staff meeting dated 17 April 2014. Items discussed included discussion about a recently received complaint, concerns about lack of porter staff to move patients and ensuring children had name bands applied in A&E.

Leadership of service

- A matron had been newly appointed to lead the nursing staff in A&E and CDU.
- Staff we spoke with felt a good rapport was developing between them and the matron and the appointment had had a positive impact on the service.
- The matron was aware of issues that needed addressing, for example regular liaison between the three A&E departments in the trust, which was not in place at the time of our visit. We were informed such liaison would be useful in imparting lessons learned from incidents and communicating good practice.
- We spoke with the band 7 sister for CDU and AEC. They were very knowledgeable about the services they delivered and proud to work in their departments. They appeared to be passionate about giving good quality care.
- We had a discussion with two student nurses who felt supported in their first week in the departments. This was particularly important in a debrief session following two cardiac arrests they had witnessed.

Culture within the service

- Staff were willing to speak with the inspectors. Staff informed us they had been told by senior managers in the trust to be honest and open in their discussions with us.
- Staff informed us morale was better, although they were concerned about the long-term future of the A&E department, which had an impact on recruitment.
- All staff we spoke with throughout the emergency department told us they felt well supported by their line managers and could raise issues with them.
- Sickness rates for nursing staff in the twelve months prior to our inspection varied across the departments. AEC had 0%, CDU 7.58% and A&E 8.2%. CDU and A&E sickness rates were above the average rates for England.

Innovation, improvement and sustainability

- The matron informed us they had used an ex-patient on the recruitment panel for a new member of staff. The patient had made a complaint about the care they had received in A&E and the matron had wanted to use their experience in the recruitment process. We were informed it had proved an excellent experience for all concerned.

Medical care (including older people's care)

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

Information about the service

There are six medical wards at the Pilgrim Hospital. These include elderly care, coronary care, respiratory medicine, haematology/oncology and a stroke unit.

We visited six medical wards, including the coronary care and stroke unit; we also visited the discharge lounge and the radiology department. We spoke with patients and staff on all of the wards and departments we visited.

In February 2015, we inspected the hospital again. We visited all the medical wards, including coronary care, the stroke unit and the discharge lounge. We spoke with patients and staff on all the wards we visited.

Because we had received some information of concerns about the cardiology service at the trust before we carried out our inspection, we looked specifically at the cardiology service being provided at the hospital.

Summary of findings

At our inspection in 2014, safety and responsiveness in the medical care service required improvement. Staff had not received appropriate training to operate intravenous infusion pumps. Also, it was not possible to establish whether staff had completed training because records were not up to date or accurate. There were not sufficient nursing or medical staff, particularly in the evenings and at weekends. We found that whilst the trust had systems in place to discharge patients in a timely manner, this had yet to be embedded so that the flow of patients was improved.

There were good systems for reporting and learning from incidents. Staff were identifying needs and risks, and taking appropriate action to manage these. However, we found that whilst good practice was taking place in relation to stroke care, this was not shared across the trust. Staff were found to be caring and compassionate. Patients and relatives were highly complimentary about the care they received and the attitudes of staff.

In February 2015, the trust's safe nursing staff levels were being supported by the regular use of bank and agency nurses in many areas, despite on-going recruitment. Staff received feedback from any serious incidents they raised, and lessons were learned. Medicines management was effective, and staff were using the sepsis care bundle appropriately. Additional electronic profiling beds and infusion pumps had been purchased, and mandatory training levels had

Medical care (including older people's care)

improved. However, there was a lack of facilities for providing cardiac monitoring on general medical wards, which could pose a risk to patients. Completion of fluid charts was variable, and patients did not always have access to, or were supported appropriately to take, fluids and nutrition. On the medical admissions unit, we saw examples of poor care and lack of dignity. Elsewhere we saw examples of exceptional care, especially for cardiology patients.

The discharge lounge was not always utilised effectively, and care of the elderly wards were not using specific care plans for those patients living with a dementia, nor using the trust's own booklet to gain a better understanding of a patient's individual needs. The strategy for cardiology services at the hospital had yet to be finalised, and nursing staff were unclear on the future of the service. The executive team were visiting the hospital frequently, and lessons were being shared within the medical directorate across the trust.

Regular morbidity and mortality reviews were undertaken and Cardiology reviews were discussed as part of Medicine Specialty Governance, although the local management team was unaware about difficulties in the cardiology service at the hospital. Staff felt better able to raise concerns without fear of reprisals.

Are medical care services safe?

Requires improvement

At both our inspections in 2014 and in 2015, we found that there was a good culture of reporting incidents and accidents amongst staff. Appropriate action was taken to analyse incidents and accidents, so that lessons could be learned and further risk reduced. Safety Thermometer, and patient safety and quality audits were carried out at ward level, and the results of these were displayed. Action plans were developed to address any shortfalls.

In 2014, we found that staff had not received the training they required to operate pumps for intravenous infusion. While two members of staff checked all intravenous medicines, only one staff member set the volume and rate of the pump, and this was not checked. However, at our inspection in 2015 we found that investment in equipment and training had been undertaken, and this issue was now resolved.

At our inspection in 2014, we could not establish whether staff had completed all required mandatory training. Records were only maintained at ward level, and these were not up to date or accurate. During our inspection in 2015, we found that mandatory training levels had improved, and the national early warning score (NEWS) was being used appropriately. There was a lack of facilities for providing cardiac monitoring on general medical wards, which could pose a risk to patients.

We found in 2014 that staffing numbers for nursing and medical staff in the evenings and at weekends were not always sufficient. The trust had carried out an acuity study to establish actual numbers required. There was an on going recruitment drive, but some wards were not yet staffed to the required numbers. At night there were only two junior doctors and one registrar for the entire medical directorate. In February 2015, the trust safe nursing staff levels were being supported by the regular use of bank and agency nurses in many areas, even though active recruitment was in place. The change of shift patterns for nurses introduced in Summer 2014 had resulted in some staff feeling extremely tired; this was to be reviewed in April 2015.

Medical care (including older people's care)

Incidents

- We spoke with staff about incident reporting. They told us that they used an electronic reporting system to report incidents.
- Staff were clear about their responsibilities around reporting incidents, and described the incidents they reported.
- In 2014 staff told us that they did not usually receive any feedback about the incidents they reported. However, during our inspection in 2015, we found that staff received feedback on important issues they had raised, such as a patient fall. Low staffing numbers were not always raised as an incident, and when they were, feedback was not always given.
- On Ward 8a we were aware that a patient had fallen and had been sent to undergo a computerised tomography (CT) scan. There was no evidence of the incident being reported on the electronic reporting system, although we were aware that the ward had staff shortages at the time.
- We asked, in 2014, how staff learned from mistakes that had occurred in the trust. Some staff told us that lessons learned would be communicated during ward staff meetings. Some staff told us that they did not receive any information about mistakes and lessons learned. During our February visit, staff told us that they received information about any lessons learned from serious incidents that had been reported. This occurred during ward meetings.
- In 2014 the matron for medicine looked at every incident reported by staff. A root cause analysis was carried out for all pressure ulcers and falls reported. This meant that themes and trends could be identified, and staff could learn from each incident, and appropriate changes made to reduce further risk.
- Medical staff held governance meetings each month. All deaths that occurred in the medical directorate were reviewed and discussed at these meetings.

Safety thermometer

- All the wards and departments we visited carried out monthly Safety Thermometer audits and patient safety and quality audits. The results of the patient safety and quality audits were displayed. Where shortfalls were identified, an action plan was in place.
- We saw that wards and departments were scoring highly in the majority of metrics measured.
- We saw that scores were low in some areas for the use of care bundles. Care bundles provide a specific pathway of care and treatment for patients with specific conditions. It was evident that the use of care bundles, begun in late 2013, had not yet been fully embedded in the majority of medical wards and departments.
- Monthly audit results were discussed at ward manager meetings. Action plans were developed at ward levels to address any shortfalls identified by the audit.

Cleanliness, infection control and hygiene

- We looked at the trust's figures for MRSA and C. difficile in the medical directorate for March 2014. The trust reported that there had been no incidents of MRSA or C. difficile during this period.
- We saw that staff in all the medical wards and departments were adhering to expected infection control policies and procedures. For example, staff washed their hands between each patient contact.
- Equipment such as gloves and aprons and hand washing facilities were readily available.
- All visitors to the ward were encouraged to clean their hands on arrival and when leaving the ward area.
- All the wards and departments we visited appeared clean and tidy. Equipment was stored appropriately with clearly segregated.
- A link nurse role for infection control had been developed. We saw that the link nurse carried out audits at ward-level. For example, an audit had been carried out to check that commodes were cleaned appropriately. Audits were carried out at ward-level.
- We saw that barrier nursing was carried out where required and this protected patients from the risk of cross infection.
- Staff we spoke with demonstrated a good awareness of expected standards regarding infection control.
- We asked the trust to send us evidence of all mandatory training that staff had received. We were only sent training figures for fire training and infection prevention training. The figures provided ranged between 445 and 805 for staff on the medical wards.

Environment and equipment

- We looked at resuscitation and emergency equipment on all the medical wards we visited. We saw that all required equipment was in place. We saw that staff were recording daily checks on resuscitation equipment.
- We noted that in 2014 there was a shortage of electronic profiling beds in all the medical wards and departments.

Medical care (including older people's care)

At our inspection in February 2015, the medical wards had recently received deliveries of electronic profiling beds. Staff informed us that they had made a big difference to the health and safety of patients and staff. More equipment had been ordered, but we were informed that the lack of electric sockets in some bed space areas had proved a problem; steps were being taken to resolve this.

- There was one computerised tomography (CT) scanner. We were told at our May 2014 inspection that there had been two days in the last two years when the scanner was not operational because it required maintenance and repair. In February 2015 we asked the trust to provide us with the maintenance and service logs for the computerised tomography (CT) scanner. These showed that regular servicing had been undertaken every three months, and ten breakdown calls had been made since our last inspection in May 2014.

Medicines

- We looked at medicine administration records and spoke with staff about medication management on all the medical wards we visited.
- Staff had their competency assessed for administering medicines.
- Staff had received additional training and had their competency assessed for administrating intravenous medicines. However in 2014, the majority of staff had not had the required training to use medical devices such as pumps to deliver intravenous fluids. The trust's own policy for medical device use and training guidelines (reviewed November 2013) states that staff must 'only use equipment that they have been trained to use and deemed competent to use'. In February 2015, wards had received delivery of new infusion pumps. When we spoke with staff they informed us that they had received training on their use.
- The hospital used a comprehensive prescription and medication administration record chart for patients, which facilitated the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- In 2014 we found that two members of staff checked all intravenous medicines. However, we observed that only one member of staff was checking that the intravenous pump was set correctly to deliver the fluid at the prescribed dose and rate.
- In 2015 we looked at the prescription and medicine administration records for nine out of 53 patients on two wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed that people were getting their medicines when they needed them; there were very few gaps on the administration records; and any reasons for not giving people their medicines were recorded. This meant that people were receiving their medicines as prescribed. If people were allergic to any medicines, this was recorded on their prescription chart.
- Medicines, including those requiring cool storage, were stored appropriately, and records showed that they were kept at the correct temperature, and so would be fit for use. We saw controlled drugs were stored appropriately, but found that some controlled drugs were not being disposed of safely. Controlled drugs are medicines which are stored in a special cupboard, and their use recorded in a special register. Emergency medicines were available for use, and there was evidence that these were regularly checked.
- A pharmacy 'top-up' service was in place for ward stock, and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- A pharmacist visited all wards daily. 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. However, staff vacancies in the pharmacy at the hospital had reduced the service provided to the wards. This meant that some patients had been kept waiting unduly for their medicines when they were discharged. The site lead pharmacy manager told us that there were plans to recruit more pharmacists to the hospital within the next four weeks, to alleviate the pressures on wards, and to ensure medicines were supplied promptly.

Records

- We looked at nursing and medical records in all the wards and departments we visited.
- We saw that risk assessments and care plans were in place for all identified risk and needs.
- We saw that all 'do not attempt cardio-pulmonary resuscitation' records had been completed appropriately, and this included a record of discussion with the patients and/or their relatives.

- In 2015 we found a patient had fallen on Ward 8a. The patient's notes had been updated to reflect the fall, and they had been treated appropriately. However, the notes did not reflect the fact that the family had been informed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that mental capacity assessments had been completed where required. We also saw evidence that staff had consulted with the safeguarding and Deprivation of Liberty Safeguarding teams when a best interest decision was made on behalf of a patient. Appropriate staff were involved in making the best interest decision. This included a social worker and psychiatrist. The patient's family were also consulted and involved.

Safeguarding

- The majority of staff has received training about safeguarding people from abuse and about conflict resolution.
- Staff knew how to recognise the signs of abuse. They knew when and how to make a referral to the safeguarding team.

Mandatory training

- In 2014 we viewed records for the training staff received, which were maintained at ward-level. Each ward or department had a clinical educator who was responsible for the planning and recording of staff training. We saw that there were many gaps in mandatory training records. We were told that staff may have had this training, but there was no record or evidence of this. In February 2015, we looked at levels of staff completing their mandatory training. Overall, mandatory training levels were good; in excess of 80%, with some wards achieving greater levels.
- In 2014 we asked the trust to send us evidence of all mandatory training that staff had received. We were only sent training figures for fire training and infection prevention training.
- Safeguarding training had been difficult to access in 2014; numbers of places available had been limited.

Management of deteriorating patients

- At the time of our inspection in 2014, the trust was using a system known as 'track and trigger'. An intervention protocol was in place for staff to follow when a patient's physiological observations were not within the normal range. In February 2015, we found that the national early warning score (NEWS) had replaced the previous system of 'track and trigger', although some staff continued to call it this. Staff were using the tool consistently to raise concerns when a patient's physiological observations were not within the normal range.
- Evidence of escalation, if required, was included in monthly patient safety and quality audits.
- We found that there was a lack of facilities for providing cardiac monitoring on wards, other than on the coronary care unit and ITU. When these beds were full, patients who required cardiac monitoring were placed on wards that had no way of carrying out the required monitoring. We were told about one recent case, where a patient had been clinically assessed as requiring a monitored bed, but was placed on a ward with no monitoring equipment. There were no telemetry facilities available at Pilgrim Hospital which would have enabled patients to have been cared for on other wards, other than for their heart monitoring viewed by the nurses and medical staff on the coronary care unit. Although this was a recognised risk amongst the medical and nursing staff, it had not been highlighted on the divisional risk register. The managers we spoke to had little understanding of the risks involved nor a strategy to address this issue.

Nursing staffing

- The required staffing numbers and actual staffing numbers for each shift were displayed on all the wards and departments we visited. We saw that required staffing numbers matched actual staffing numbers during our inspections.
- In 2014 we were told that an acuity review had been carried out for all medical wards and departments. At our inspection in 2015, we saw that recruitment to meet the new safer staffing levels was in place, and that agency and bank staff were used to fill any shortfalls within the regular staff numbers.
- In 2014 we found that the older people's care wards were not staffed to the required establishment. Additional nurses were required for each shift. Staff told us that at night there were only two qualified nurses on duty. They were extremely busy and required additional staff. Nursing staff levels on the wards we inspected in 2015 were variable. Ward 7a (haematology/oncology) had 21 beds and three qualified nurses, three healthcare support workers and a band 7 nurse on duty. This meant

that there were sufficient staff to provide good care to patients. One chemotherapy trained nurse was always on duty. On the stroke unit we found that their staffing was not up to the established level.

- Ward 6a, a ward providing care for elderly female patients with complex care needs, 80% of whom had a dementia, had six new members of staff, but still required four more. Two members of staff were also due to retire in the near future. The shortfall in staff was covered by staff undertaking additional shifts and by agency staff.
- Staff told us that they informed the sister in charge when the ward was busy. Staff were moved from other wards where possible, or bank staff were used.
- Patients told us in 2014 that they did not have to wait for staff to attend to them, and they received the care, treatment and support they required. However, at our inspection in February 2015, Ward 8a staff told us that they had been very short of staff over the previous few months. A patient on the ward told us the only issue they had was with a shortage of staff. "They need more staff, they're rushed off their feet and when you ring the bell it takes a long time to get answered." Another patient told us, "call bells ring a lot at night". On Ward 1/ discharge lounge we spoke with a patient who had been a patient on the ward for three weeks. They told us, "it is very evident that there is a shortage of staff. The other night there was one nurse and two healthcare support workers for 27 people. That cannot be safe".
- The trust did not increase bed capacity for Winter pressures in either the 2013 or 2014 Winter period. In 2014 we were told that instead of increasing capacity, the trust invested in community initiatives for hospital admission avoidance. The trust sent us their bed occupancy figures for March 2014, and reported that bed occupancy was at 94% for this period. This was above the England national average of 85% for average bed occupancy.
- We spoke to nursing staff about the new shift system that the trust had introduced in August 2014. The new system had resulted in the majority of nursing staff being required to complete a combination of shifts, some of which meant undertaking 'long days', such as 13 hours, sometimes as many as three a week. Reaction to the long days was varied. One nurse who had joined the trust last year told us that they were leaving and the long days were one of the contributing factors; some staff informed us that the shifts made them extremely tired, whilst others enjoyed them. The trust informed us that the system would be reviewed in April 2015.
- We were aware that the trust had a long-term recruitment plan in place. Figures the trust supplied stated that there would be 2.6 healthcare support worker vacancies and 4.86 whole-time equivalent (WTE) vacancies after the arrival of new starters who had already been recruited. The hospital are currently working with Lincoln University to attract newly qualified staff to the hospital.

Medical staffing

- In 2014 we were told that medical cover at weekends and out-of-office hours was insufficient. There was consultant cover, with one resident consultant and one on-call at weekends. At our inspection in 2015, we found that from 11pm there were only two junior doctors and one registrar for the entire medical directorate. Only one junior doctor was available for the medical wards; the other managed care for patients on the medical admissions unit and the emergency department. A member of the medical staff stated that they felt medical cover at night could be unsafe if the registrar was busy with a patient, but generally it was a safe service.
- At night, there were only two junior doctors and one registrar for the entire medical directorate. This resulted in wards waiting several hours for the doctors to attend, and junior doctors finding it difficult to complete all the ward jobs required. Medical staff we spoke with in February 2015 told us that the care of the elderly service required more junior staff.
- There were medical staffing vacancies within the cardiology service at the hospital. The trust was finding it very difficult to recruit to the consultant cardiologist vacant posts, and had recently reviewed the roles in an attempt to make them more attractive as part of the Trust Wide Cardiology Strategy. The vacancies meant that there were some gaps within the on-call rota if interventional cardiac procedures were required. These vacancies were being covered by the on-call consultants at Lincoln County Hospital.
- The cardiology consultants were not well supported with middle grade doctors, and there was only one specialist registrar at Pilgrim Hospital. This meant that the pressure and workload on the substantive

cardiologist was very high. We spoke to one of the substantive cardiologists at Pilgrim who was reviewing ward referral without any middle or junior doctor support. We were informed by the trust that the on call cardiology consultant has no other duties so time is adequate for an independent ward round.
- The trust informed us that the medical directorate at Pilgrim Hospital required six additional doctors at the hospital, three of which were consultants.

Major incident awareness and training
- Pilgrim Hospital, Boston was part of the trusts major incident plan and took children from Grantham out of hours.

Are medical care services effective?

Requires improvement 

Weekend arrangements for a computerised tomography (CT) and ultrasound were operated as an on-call system. Stroke breach analyses for March 2014 recorded that the majority of breaches occurred out-of-hours. This meant there may be a direct correlation between breaches to the stroke target and the weekend arrangements for CT scanning.

The multidisciplinary teams worked well together. There were good examples of seven day working on the stroke unit. We saw that patients received effective care, such as appropriate care to prevent pressure ulcers. On the coronary care unit, staff were using care bundles for heart failure where this was applicable. Staff were well engaged in the importance of meal times and we saw that all grades of staff were present and assisting patients with their meals.

In February 2015 we had not planned to review this key question as it had been rated good. However we noted that pain assessments were not competed correctly and patients were left in pain. Completion of fluid charts was variable, and patients did not always have access to, or were supported to take, fluids and nutrition. Therefore we have rated this key question as requiring improvement.

Evidence-based care and treatment
- The trust was following NICE Quality standards 4 and 5 for care of stroke patients.
- Nursing care plans were in place for all assessed needs.
- We spoke with staff about care plans. Staff were not clear about the research that underpinned the care plans they were using. Staff reported that the care plans were time consuming and felt they were "drowning in paperwork".
- The hospital does not meet the minimum number of operators for a sustainable pacing service according to national guidance. The trust suspended the service due to concerns raised in November 2014 and will recommence when Heart Rhythm UK standards can be met.

Pain relief
- Staff carried out hourly intentional rounds. Assessment of pain was included in the intentional round. Staff took appropriate action when pain was identified. For example, staff assisted the patient to change their position and or administered prescribed analgesia.
- During our unannounced inspection in February 2015, we looked at the care of a patient on the medical admissions unit. We saw that the nurses had written in the records that the patient was in pain, yet the patient's pain scores indicated the patient was in no pain. There was no pain relief prescribed, despite them having a medical condition that could have meant they were in pain. We spoke with the patient, and they told us they had some pain. We raised our concerns about the care of this patient during our inspection.

Nutrition and hydration
- We observed the lunch time meal being served during our inspection in 2014. A bell was sounded to alert staff that lunch was arriving. Staff responded and ensured that they were ready to assist patients with their meal. All grades of staff were involved in serving and assisting patients. We saw that patients received their meal promptly. Staff assisted patients who required this in an appropriate and sensitive way. During our inspection in February 2015, we saw a lunchtime service on Ward 6a. We saw one member of staff supporting four patients in a bay to eat their meal. Infection control practices were in place in the bay. The member of staff did not sit down with one of the patient's to support them to eat their food, and had no meaningful engagement with them. We discussed this with a senior member of staff, who informed us that there were not enough staff to go into the bay to help.

- All patients had their risk of malnutrition assessed. Where risk was assessed, appropriate action was taken. Staff referred patients to a dietician when this was required.
- Staff maintained records of food and fluids consumed in 2014. In February 2015 we looked at the fluid balance charts for patients. Their completion was variable, with some patients having the amount of liquid placed in the chart but not what it was.
- A coloured cup system had been introduced in the elderly care wards. The colour of cup indicated to staff the level of assistance required by each patient. The use of a coloured cup, as opposed to a clear glass, was also beneficial to patients with cognitive impairment.
- During our unannounced inspection, we visited the medical admissions unit. We observed one patient who did not have their drink within reach. This patient had a visibly dry mouth. Their teeth appeared to be coated in a substance which looked like plaque. We were not able to ascertain from talking with the patient, looking at the records, and talking to the staff caring for the patient, if they had received help and support to clean their teeth. It was not clear from the records how much fluid or food this patient had received during the day. We reported our findings to the senior nurse on duty who ensured that action was taken.

Patient outcomes

- Weekly stroke meetings were held. Meetings were attended by stroke unit and A&E staff, to review the care and treatment provided to each patient. Breaches to stroke targets were analysed and action plans developed. The trust sent us stroke breach analysis reports for the weeks beginning 24 March to 21 April 2014. Breaches to the stroke targets included breaches to the four hour target for admission to the stroke unit, and breaches to the four hour target for swallowing assessment. The breach analyses for the week beginning 24 March 2014 stated that the breaches to the one hour target for CT scanning mostly occurred out-of-hours. This meant that there may be a direct correlation between breaches to the stroke target and the weekend arrangements for CT scanning.
- We saw that scores were low in some areas for the use of care bundles. Care bundles provide a specific pathway of care and treatment for patients with specific conditions. It was evident that the use of care bundles, begun in late 2013, had not yet been fully embedded in the majority of medical wards and departments.
- In February 2015 we found the use of care bundles, especially those for sepsis, had been embedded into practice, with staff having received training on their use. However there was no care bundle for patients who had had a stroke. We were informed that a project was in place looking at how the hospital could devise one incorporating all best practice issues.
- The trust used a system known as 'plan for every patient'. This meant that discharge-planning commenced on admission. A board detailing the patient plan was used by staff to identify any delays to the patient's stay and therefore, action could be taken to minimise this. Staff reported that this was working well, and ensured that patients' were discharged in a safe and timely way.

Competent staff

- The majority of staff we spoke with had not received training with regards to dementia care.
- We were told that dementia care was included in the induction training for all healthcare assistants.
- Staff told us that they did receive appraisal from their line manager.
- Patients we spoke with reported that staff were competent and knew how to meet their needs.
- A doctor we spoke with in February 2015 told us that they were enjoying their role, but felt they needed more teaching on acute medicine.

Seven-day services

- Physiotherapists, occupational therapists and speech and language therapists worked seven days a week on the stroke ward.
- Pharmacy was available Monday to Saturday until 12pm. We were told that if patients were discharged after this at the weekend they could be provided with a prescription to obtain their medicines. This did, however, mean that they would have to pay for their prescription.
- There were two consultants on duty at weekends. One in residence and one on-call.
- We were told that there was a daily senior review for all patients. This meant that patients were seen by their consultant or register on most days of the week. We observed medical staff conducting ward rounds.

Medical care (including older people's care)

- CT and ultrasound staff did not work weekends but were on-call. The trust breach analyses for the week beginning 24 March 2014 reported that breaches to the one hour target for CT scanning occurred mostly out-of-hours.

Are medical care services caring?

Requires improvement

Patients and relatives were highly complementary about the care they received and the attitudes of staff. We observed staff treating patients with care and compassion. Patients had their privacy and dignity maintained.

In February 2015 we had not planned on reviewing this key questions as previously it had been rated as good. However we saw on the medical admissions unit examples of poor care and lack of dignity. It was judged that this care was so poor that the key question requires improvement. We also saw examples of exceptional care for cardiology patients.

Compassionate care

- Nursing staff carried out hourly intentional rounding. This meant that staff had contact with each patient at least hourly and attended to their comfort and needs. We saw that staff were carrying out these rounds and patients confirmed that this was the case.
- We spoke with patients and visitors on all the wards and departments we visited. The vast majority of patients and visitors were complementary of the care, treatment and support they received.
- During our unannounced visit to the hospital on the evening of 1 February, we saw a patient who was transferred to the medical admissions unit, and their dignity was not maintained. We raised our concerns about this at the time of the incident.
- On the same unit we saw a patient who had not been assisted to shave. They had been an inpatient for three days.
- During our visit we found that nursing staff in cardiology at Pilgrim Hospital were exceptional, and were providing very good care to patients. They were well supported, had received specialised training, and morale was high.
- The NHS Friends and Family Test was used on all wards and departments we visited. The results of this were displayed in the wards and departments we visited. The results were mostly positive

Patient understanding and involvement

- Patients we spoke with told us they were involved in making decisions about the care and treatment they received.
- We saw that staff maintained patients' privacy and dignity. Screens were pulled around patients' beds and signage was in place warning staff and visitors not to enter.

Emotional support

- A family and carer support coordinator from the Stroke Association visited the stroke ward twice a week to offer advice and support to patients and their carers.

Are medical care services responsive?

Requires improvement

The trust was taking action to decrease the average length of patients' stay and improve the discharge process. However this was taking time to embed. The ability of a trust to conduct safe and timely discharges is important to the overall patient flow through the hospital. The trust's dementia strategy was underway, but had not been fully implemented. However, the clinical educator on the elderly care wards had completed training for dementia care and planned to cascade this to all staff. The Alzheimer's Society had an office based near the elderly care wards. This resource provided advice and guidance to people with dementia, their carers and to staff.

In February 2015, we found bed occupancy levels had increased over the previous three months, and the discharge lounge was not always utilised effectively. Care of the elderly wards were not using a specific care plan for those patients living with a dementia, nor using the trust's own booklet to gain a better understanding of a patient's individual needs.

Access and flow

- The trust's bed occupancy at the time of our visit was at 94%. High bed occupancy of over 85% can affect the quality of care for patients and the orderly running of the hospital. 5.65 % of medical patients were being treated on wards in other directorates during this time. We were told that each medical team was allocated a surgical ward for outliers. This meant the medical team could more efficiently manage the care and treatment

of patients on wards in the surgical directorate. We were told that patients were not moved more than twice. We were told that patients with dementia were never placed on wards in other directorates.

- We were aware that the bed occupancy levels across the trust had increased considerably over the previous three months prior to our visit, because of the elevated number of patient attendances. Although this had reduced slightly, pressure on beds was still high when we visited the hospital.
- Wards we visited told us of the number of medical outliers they had experienced. Medical outliers are patients who are cared for on wards that do not specialise in medicine. Staff we spoke with told us that they felt confident to care for all patients that they had on their wards.
- The pathway for cardiology patients on outlying non-cardiac wards brought up some concerns. We identified a high risk heart failure patient who had a delayed diagnosis and management plan- in part because of his care on a non-specialist on a non-cardiac ward. The trust are carrying out a baseline assessment against NICE Guidance but this was not completed on all sites at the time of the Inspection.
- We visited the hospital discharge lounge and spoke with staff who were members of the hospital discharge team. We were told that additional funding had been allocated to the hospital discharge team and this was because there had been a decrease in the average length of stay for patients.
- The discharge team visited wards daily and became involved in discharge planning as soon as patients were admitted. The hospital discharge team worked closely with staff on the wards to manage the discharge process.
- We looked the use of electronic discharge documents and saw that this process was working well.
- When we visited the discharge lounge during February 2015, we were informed that the area was not always being utilised effectively. One patient complained that they had been moved to the discharge lounge too soon, and they had then had to be re-admitted.
- A member of staff told us that some of the wards would not send patients to the discharge lounge because it allowed more patients to be admitted and increased their workload.
- Wards had access to the computer service of the provider of ambulance transport for the hospital. This showed the booked pick-up times of patients. If there was a ten minute delay, this meant that the booked slot was lost. A pilot project was in place which had improved patient flow, owing to an ambulance and its crew being based in the discharge lounge.

Meeting people's individual needs

- Face-to-face translation services and telephone translation services were available at the trust.
- The Alzheimer's Society provided a service to people with dementia. They were based near the elderly care wards but offered support and advice for people with dementia throughout the hospital. Advice and support was provided to patients and carers regarding effective communication and resources and support available to people when they left hospital. Only one patient had been referred to the Alzheimer's Society team in April 2014. We were told that the majority of referrals were made by occupational therapists and the psychiatrist.
- During February 2015, we spoke with a representative from the Alzheimer's Society who was based in the hospital on Ward 6b. They informed us that their service was used on a regular basis and funding for the provision of the service had recently been extended to March 2016. They took referrals from any ward in the hospital who requested it, but they could not support patients or their families until the ward had received permission from the family to do so. They were also able to facilitate support in the community once a patient was discharged.
- The majority of staff we spoke with had not received training for dealing with dementia. We were unable to establish the exact number of staff who had received training about dementia, because training records were maintained at ward-level. Each ward and department were in the process of updating their training records.
- The clinical educator employed in elderly care had undertaken a course in dementia care and planned to cascade this training to other staff.
- There was no dementia-specific care planning process in place. The trust had launched a dementia-specific 'This is me' form for staff to use to gather important information about the person, and therefore, improve communication with the patient. This form was not yet routinely being used, but was completed by Alzheimer's Society staff if a referral was made.
- In February 2015, we found that there was no specific care-plan for patients with a dementia. Although the

trust had produced a booklet called 'All About Me' printed in 2014, they were not being used. The purpose of the booklet was to gather information about each patient in order that staff could have an understanding of a patient beyond their illness. It included details such as how they best communicated, how they took their medicines, and their daily routine. We spoke to staff on the care of the elderly wards, and they did not use the booklet, with one member of staff stating that they had not seen the booklets. The Alzheimer's Society used a similar booklet called 'This is Me'.

- Dementia care was included in the induction training for all healthcare assistants.
- A psychiatrist was employed by the medical directorate. Staff reported that the psychiatrist was a valuable resource and was proactive in their approach to the care and treatment of patients with dementia.

Learning from complaints and concerns

The trust had recently re-launched their Patient Advice and Liaison Service. We saw that information about how to contact Patient Advice and Liaison Service was displayed around the hospital.

Are medical care services well-led?

Requires improvement

In 2014 we found this key question was rated good. However in 2015 we found a number of concerns in the service and have re rated this service as requiring improvement to lead improvements. In 2014 we found that governance systems were in place to assess and monitor risk and effectiveness. Responsibilities were clear, and problems were detected, understood and addressed. However, there was a lack of sharing of good practice with other hospitals in the trust. An example of this is the good practice within the stroke care pathway, which was in place at Pilgrim Hospital, but not shared or implemented at the other hospitals where patients who had had a stroke were treated. However, at our inspection in 2015, we found that the trust had implemented quarterly clinical senate meetings and monthly matrons meetings, where staff from across the trust could meet to share ideas and discuss issues. Staff at Boston Pilgrim Hospital were aware of these meetings and had attended.

Staff felt supported and managers were visible, approachable and accessible. Staff reported that they regularly saw members of the trust board around the hospital. Staff felt confident in raising concerns.

In February 2015, the strategy for cardiology services across the trust had been agreed at Clinical Executive Committee in December 2015. However nursing staff were unclear on the future of the service. The executive team were visiting the hospital frequently and lessons were being shared within the medical directorate across the trust.

Apart from cardiology, regular morbidity and mortality reviews were undertaken. There was a general lack of knowledge by the local management team about difficulties in the cardiology service at the hospital, and no service lead was in post to raise this within this speciality. Staff felt better able to raise concerns without fear of reprisals, and in general, staff felt supported, although because of recent high activity, morale amongst nursing staff had fallen slightly.

Vision and strategy for this service

- Staff felt supported and managers were visible, approachable and accessible. Staff reported that they regularly saw members of the trust board around the hospital. They told us that the deputy chief executive held briefing sessions for all staff.
- In February 2015, there was a draft cardiology strategy in place, and some final changes were being made. Nursing staff in cardiology were not clear about the strategy for their service at Pilgrim Hospital.
- Staff told us members of the executive team were seen at regular intervals in the hospital; in particular the chief executive officer and the acting chief nurse.

Governance, risk management and quality measurement

- Ward managers attended monthly meetings to review and discuss safety concerns. Action plans and lessons learned were communicated to staff at ward meetings.
- Medical staff held monthly governance meetings.
- We were told that a quality and safety officer had recently been employed.
- In 2014 we found that the stroke pathway within Pilgrim Hospital was working well; however, the lessons learnt had not been shared with the other hospitals in the trust. However, at our inspection in 2015, we found that doctors were aware of the trusts quarterly clinical

senate, which is a forum for sharing good practice across the trusts, and matrons from across the hospitals in the trust were meeting monthly, to receive and disseminate information, as well as to exchange ideas.

- In February 2015, there were no speciality specific mortality and morbidity reviews of cardiology patients, these were undertaken as part of Medicine Specialty Mortality review meetings; however, we were told these dedicated Cardiology Review Meetings were due to start in March 2014 at pan trust level. The frequency of the pan trust meetings needs to allow sufficient time to hear all of the local issues at Pilgrim hospital.
- As well as monthly governance meetings, regular mortality and morbidity meetings were also held other than in cardiology, to review deaths and to understand if lessons could be learned which would lead to better care.

Leadership of service

- We observed that matrons and ward managers were highly visible on the wards and departments we visited.
- Staff we spoke with told us that they felt supported, and their managers were approachable and accessible; but at our inspection in February 2015, because of the recent high level of activity, they were very tired, and some nursing staff said morale had dropped.
- Medical and nursing staff spoke highly of each other, and reported that working relationships were effective and supportive.
- We had received concerns about the cardiology service at Pilgrim Hospital before our inspection, and we looked at these in detail. We found there was a lack of service-specific leadership and governance. Although we did not find evidence that outcomes for patients had been adversely affected, the service was reliant to some extent on the goodwill and commitment of the medical staff. This may not be sustainable in the longer term. Risks to the service were not being identified and addressed through the trusts governance processes.
- In February 2015, cardiology staff were well supported, had received specialised training, and morale was high.
- There appeared to be a significant gap in clinical leadership between the divisional clinical director at Pilgrim hospital and the cardiology pan trust lead, based at Lincoln. There was no local cardiologist at Pilgrim hospital to act as the local cardiology lead to provide leadership on local issues and liaise between the pan trust cardiology lead and the divisional clinical director for medicine at Pilgrim hospital.

Culture within the service

- In February 2015, there was good team working on the cardiology ward, between staff of different disciplines and grades. Medical and nursing staff spoke highly of each other, and reported that working relationships were effective and supportive.
- Nursing staff working on the cardiology ward were exceptionally positive about working on the ward, and were committed to providing the best care possible for their patients. Junior staff felt very well supported.
- We were given an example of where a clinician had raised a concern about patient safety, but their concerns were not taken seriously. The clinician felt confident to challenge further, and their concerns were then partially addressed.
- We spoke with a member of staff who had worked in the hospital for the previous twelve years. They told us that there had been a 'huge change' in the culture over the previous two years, and they felt confident to take any concerns they had to their line manager.

Public and staff engagement

- Staff we spoke with were aware of the Listening into Action™ initiative and were able to provide examples of improvements made.

Surgery

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

Information about the service

The surgical unit at Pilgrim Hospital, Boston, included 10 theatres (and a further obstetric theatre), five surgical wards and a day surgery unit. The hospital undertook elective and emergency general surgery, vascular surgery, urology and orthopaedics, among others.

In 2014 we observed care in theatres and on three of the wards and in the endoscopy suite. We examined records and spoke with staff and patients using the service. In 2015, we were informed that Ward 3A was being used as a medical ward rather than surgical ward for a short period, to manage Winter pressures.

Summary of findings

While surgical areas were clean, there were some areas for improvement in the safety of the service, with respect to the recording of care, which could have an impact upon the safety and welfare of patients. In 2014, records relating to VTE and catheter care were not always completed. These were areas in which the trust has had higher levels of incidence and infection than expected. In 2015, we saw that the Safety Thermometer reflected inconsistency in completion of records across the surgical wards for falls, catheter care and some VTE assessments. We found that one ward was very cluttered in corridors, and also the medicines room, which impeded access to other equipment. In 2014 on one ward, we saw evidence of a high level of error in the prescribing of medicines. This put patients at risk of receiving incorrect medication. In 2015 we saw that this had been rectified.

The service provided effective and evidence-based care and treatment. There were excellent audit results for patients treated for fractured neck of femur, and theatres operated to best practice guidance. Enhanced recovery protocols were in place for some colorectal and vascular surgery.

Staff were seen to be caring and compassionate while delivering care. Patients' privacy and dignity was maintained. Patients we spoke with were positive about the care and attention they had received while they were inpatients. Surgical wards scored highly in the NHS Friends and Family Test.

Surgery

Services were responsive to people's individual needs. However, there were issues regarding capacity and flow in the service. There were over 600 cancelled operations for the hospital for the last year, with the majority being because there were no beds available. In 2014 data from NHS England for February 2014 showed that general surgery and orthopaedics were missing their 90% referral to treatment time target. In 2015, we saw that the treatment times for surgeries carried out at Pilgrim Hospital were still not meeting treatment time targets. Senior medical staff were concerned about the number of high dependency unit (HDU) beds, particularly as all patients with epidural analgesia required one.

The service was well-led. Staff reported that there had been significant positive change in the last year, and felt that at directorate and ward-level, they were moving in a clear direction. We spoke with staff, who were proud of the quality of care they provided, and were clear of their department and hospital's values.

Are surgery services safe?

Requires improvement

Staff were aware of the mechanisms for incident reporting, and said that they had received feedback about previous incidents, and had changed practice. The Safety Thermometer was well used, and visible across clinical areas. Areas were clean and staff wore appropriate PPE to prevent cross infection and contamination. Staff had a good knowledge of safeguarding and the Mental Capacity Act 2005. We saw that a recent Mental Capacity Act 2005 assessment had been completed.

In 2014, patients who became unwell were identified and managed in line with good practice ('track and trigger'). In 2015, the trust used the national early warning score (NEWS). In 2014, nursing staffing had improved, and there were adequate medical and nursing staff for the unit. In 2015, we saw that nurse staffing had deteriorated on two of the wards we visited, with senior staff reporting difficulties in managing the rota. Whilst most shifts were covered across surgery, we saw a number of occasions when there was a shortfall in registered nurses. One senior nurse described their staffing situation as "fragile".

In 2014, while VTE assessments had been completed to a high level for the previous year, we saw that not all had been completed. Not all records were well kept, some assessments for the management of people with catheters was not always completed, even though the trust had a higher than average rate of catheter-associated infection. In 2015, we saw that the Safety Thermometer reflected inconsistency in the completion of records across the surgical wards for falls, catheter care and some VTE assessments. Records we reviewed confirmed this inconsistency. However, the recording of cannula catheter had improved since our visit in 2014, and was good. In 2014, on one ward we saw a high number of prescribing errors that were unsafe and so required improvement. In 2015, we saw there had been a significant reduction in prescribing errors on the ward.

Incidents

- Staff on the wards and in theatres were able to describe the steps to take in the event of a serious incident, the role of investigation and potential change in practice.

- We spoke with staff about a serious incident in the theatres regarding the use of skin preparation preoperatively. They told us how they had liaised with all staff and changed practice to ensure the incident did not happen again.
- Staff were aware of the importance of incident reporting and told us they were encouraged to report incidents. Staff told us that they received feedback on incidents when they occurred. We saw in the team meeting minutes that staff were updated as to the outcomes of incidents and any change of practice, as well as other quality indicators and outcomes.

Safety thermometer

- The safety and quality dashboard (SQD) was clearly displayed on the ward, and could be seen by staff, patients and visitors. We were told that it was completed monthly.
- Most of the results were positive; however, some elements of care scored poorly on the Thermometer.
- In 2014, we saw from audit data that VTE assessments were not always completed correctly. Some clinical areas had a better record than others. On one ward, the senior nurse was unable to locate the VTE audit for us. On another ward, only 58% of audited VTE assessments had been completed correctly in the month before our inspection, though compliance had been at 98% for a full year previously. A junior doctor was aware of the VTE policy and appropriate prescribing. In 2015, we saw audits that showed clinical areas had improved VTE assessment recording. We reviewed 15 records, and found 11 to be properly completed and 4 not completed. This included patients at high risk of VTE, such as orthopaedic patients. We saw, however, that appropriate prophylaxis had been prescribed for those patients.
- In 2014 we saw that catheter care paperwork was audited to be completed correctly 75% of the time on one ward. We reviewed three sets of notes for patients with catheters, and found all three were not fully completed. Data we had prior to the inspection showed that the trust had a higher level of catheter-associated infections than the England median. In 2015 we saw from audit data that completion of catheter care records was inconsistent across surgery, with some wards reporting high compliance and others reporting less well. For example, one ward for January 2015 had a 75% compliance with catheter care documentation, whilst another reported 90%. We reviewed 11 records and found that seven catheter records were completed correctly, but four records were either not completed, or not fully completed.
- In 2014 for patients with a cannula, 75% of the records audited had been completed on every shift, or the patient demographics completed. We were told that the main reason for the result being at 75% was that, in some areas, the paperwork was not started correctly before the patient was transferred to the ward environment. The use of cannulas, particularly longer than several days, is associated with a greater risk of infection. In 2015, we saw that cannula records had improved, with ward areas achieving results of greater than 80% completion. All but one of the records we reviewed had completed cannula assessments.
- In 2015 we saw from ward audit data, a low level of completion of falls risk assessments, with one ward showing a completion rate of 70%, and another of 60% for January 2015. We reviewed nine falls risk assessments, and found three to be completed, and six not completed or not fully completed. On one ward, we also saw that the audit result for use on the sepsis care bundle was at 30% for January 2015.
- Data about the trust showed that there were low levels of pressure damage on the surgical wards.

Cleanliness, infection control and hygiene

- Data we reviewed prior to the inspection showed that MRSA bacteraemia infections were within statistically acceptable levels (with one case reported).
- The ward was clean and we saw staff regularly wash their hands between patients and between interventions. Staff were bare below the elbows, in line with trust policy and national guidelines.
- We saw environmental cleanliness audits were regularly completed and scored highly.
- Personal protective equipment (PPE), including gloves and aprons, was readily available for staff and visitors should it be required and alcohol hand gel was placed at the entrance and exit to the ward and around the clinical environment.
- Patients who required barrier nursing, or isolation, were managed in a side room and the isolation policy was adhered to.

- The unit participated in the ongoing surgical site infection audits run by Public Health England. The last published results for 2012/2013 showed infections were within a statistically acceptable range.
- We saw that bed space decontamination checklists had been completed and signed.

Environment and equipment

- The environment on the unit was safe, with sufficient space for the safe movement of patients, staff and visitors.
- Side rooms were available if required, and again, there was sufficient space to ensure the safe movement of patients who may require the use of lifting equipment, such as hoists.
- Equipment on the unit was clean and maintained at regular intervals, as instructed by the manufacturer.
- The resuscitation equipment was checked daily and was found to be correct.
- In 2014 one of the wards included a seven bed surgical assessment unit (SAU). We found that beds in the SAU shared a suction point (one point to two beds). We asked a senior nurse about this, and they told us that they had not considered the issue previously. Following the inspection, we received advice that the potential acuity of these patients would normally warrant a suction point for each bed space. We were made aware of plans to move the SAU to another part of the hospital in the future. Most beds/wards in the hospital had one suction point for every two beds. In 2015, we saw that the SAU was in the same location, and that two beds still shared a single suction point, though the acuity level of patients was low at the time of our visit.
- We saw a member of staff decontaminating used endoscopes in the endoscopy suite. They demonstrated an excellent knowledge of decontamination and sterilisation methods, which were in line with guidance from the Joint Advisory Group on GI Endoscopy (the Group) and others.
- In 2015, we visited the Bostonian Unit, which originally had been purpose-built as an 18 bed private ward, but was now predominantly used for NHS patients requiring a variety of specialist treatment, including urology, general surgery, orthopaedics and medical care. We saw that it was a very cluttered environment, with trolleys, drawers, wheelchairs and clinical equipment, such as ultrasound and ECG machines, emergency equipment and linen trolleys, all in the main corridors of the unit. We also found the medicines cupboard to be very cluttered, with numerous boxes on the floor that reduced floor space and impeded access to other equipment. We found two boxes resting on a bag of intravenous fluids.

Medicines

- Medicines were stored correctly and kept locked. Medicines that required refrigeration were kept in a locked fridge, and the temperature of the fridge was checked daily.
- We saw two members of staff correctly checking controlled drugs, and checking the prescription and patient details correctly.
- In 2014 we were made aware by staff of prescribing errors on one of the wards. We reviewed the copied drug charts and found that there had been numerous prescribing errors in the preceding six months, including duplicate prescriptions for paracetamol, a patient prescribed a medication they had an allergy to, the wrong method of administration for commonly used medicines, and illegible writing and signatures. Staff told us that they had completed incident forms for these errors. In 2015, we saw that there were less prescribing errors reported on the ward. Staff we spoke with confirmed there were significantly less errors, and that medical and nursing staff had taken ownership of prescribing practice on the ward.
- In 2015 we were aware of a meeting in December 2014 that discussed the security of medicines in theatres following a coroners ruling. We saw that half of the medicines cupboards in anaesthetic rooms were left unlocked when unattended, and that medicines fridges were also unlocked and unattended.
- The hospital used a comprehensive prescription and medication administration record chart for patients, which facilitated the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts, to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for ten out of 51 patients on two wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them, there were very few gaps on the administration records, and any reasons for not giving

people their medicines were recorded. This meant that people were receiving their medicines as prescribed. If people were allergic to any medicines, this was recorded on their prescription chart.

- Medicines, including those requiring cool storage, were stored appropriately, and records showed that they were kept at the correct temperature, and so would be fit for use. We saw controlled drugs were stored appropriately, but found that some controlled drugs were not being disposed of safely. Controlled drugs are medicines which are stored in a special cupboard, and their use recorded in a special register. Emergency medicines were available for use, and there was evidence that these were regularly checked.
- There was a pharmacy top-up service for ward stock, and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- A pharmacist visited all wards daily. 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. However, staff vacancies in the pharmacy at the hospital had reduced the service provided to the wards. This meant that some patients had been kept waiting unduly for their medicines, including when they were discharged.
- The site lead pharmacy manager told us that there were plans to recruit more pharmacists to the hospital within the next four weeks, to alleviate the pressures on wards and to ensure medicines were supplied promptly.

Records

- All records were paper-based. Medical notes were kept in designated trollies and other records, such as observation and drug charts were kept at the end of beds or outside isolation rooms.
- All staff used the same documentation to ensure good communication and consistency in care provision.
- Record audits were completed for some elements of the records such as DNA CPR forms.
- We saw that the majority of risk assessments and associated tools, such as pressure area assessments and falls were completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were no patients on the wards we inspected that were subject to Deprivation of Liberty Safeguards.
- Staff we spoke with demonstrated a good understanding of the Mental Capacity Act 2005 and were aware of the need for assessments and the constituents of 'best interest' decisions.
- We saw one Mental Capacity Act 2005 form that had been completed. A best interest meeting had been held with the relevant professionals and family members.

Safeguarding

- Staff had received training in safeguarding and were aware of the actions they should take, and the team they should contact, if they were concerned about a safeguarding issue.

Mandatory training

- Staff received mandatory training in elements of care such as moving and handling, basic life support and infection control. Staff we spoke with on the ward and at focus groups told us they were up to date with mandatory training, which was a mixture of classroom-based training and e-learning. They told us that the provision of training had improved, though it was sometimes difficult to complete the e-learning, as there was not always easy access to a computer.
- Evidence from a training matrix showed that junior doctors had also completed mandatory training.
- Theatre staff were all up to date with intermediate life support training.

Management of deteriorating patients

- In 2014, the surgical unit used the 'track and trigger' method to identify deteriorating patients. We were told that the national early warning score (NEWS) system was to be implemented by the trust, which is the current best practice. The outreach team would be providing training for staff in the new system. In 2015, we saw that NEWS had been implemented across the surgical pathway. Records we reviewed showed that it was used correctly, and that patients were escalated for review if they scored highly on the tool. Three staff we spoke with told us that they were confident in using the tool.
- If a patient caused concern on 'track and trigger', an outreach service was provided seven days a week to support staff and patients in the ward areas. Out-of-hours, the service was maintained by the hospital night-time team.
- If the patient required further care, there were level 2 and level 3 critical care beds available at the hospital. Further specialist care would require transfer.

Surgery

Nursing staffing

- The Keogh Mortality Review in 2013 had concerns regarding the level of staffing.
- In 2014 all staff told us that staffing on the unit had improved in the last year. Uplift in nursing staff had occurred across all the surgical wards at Pilgrim Hospital. On two wards, we saw that the staffing levels were very close to establishment. We were told on one ward that previously, there was approximately one registered nurse to ten patients, but this was now one nurse to eight patients.
- In 2015 we saw that two wards had a number of vacancies for registered nurses. The new shift patterns meant that many gaps in rotas were often filled with staff doing overtime. However, on one ward we saw that there was a shortfall of registered nurses on shift for a number of shifts in January 2015. One senior member of staff told us that the staffing had got worse in the last year due to vacancy levels, whilst another senior member of staff described their staffing position as "fragile". We were told that due to staff movement within the hospital at night that some wards regularly operated with two registered nurses on duty, rather than three, but this was not reflected on the rotas.
- We saw rotas on two wards that showed staffing levels were being maintained. Senior staff reported that they were able to book bank and agency staff to fill shortfalls, as required.
- A senior nurse told us that they were actively managing the skills mix on the ward, as many of the nurses were comparatively newly qualified or from abroad. They explained to us how they were supporting the new staff, and upskilling them for the surgical ward environment.

Medical staffing

- Medical cover was primarily provided by the surgical/ orthopaedic consultant lead teams. Out-of-hours cover was provided by the on-call teams. Consultants were supported by a mix of mid-grade and junior doctors.
- Senior staff told us that they had moved away from locum usage and now had more permanent consultants who were developing the middle grade medical staff.
- We spoke with two junior doctors and others in focus groups, who told us that out-of-hours cover was sufficient and that they felt supported in their role.
- Nursing staff said that they could get patients reviewed when required and they had no concerns about the support they received from medical colleagues.
- Out-of-hours cover was provided by the on-call team, but all patients received senior review at weekends. The night practitioners (nursing) attended the medical handovers in the evening to identify and prioritise patients.

Major incident awareness and training

- There were two World Health Organization (WHO) champions in theatres. Briefings before surgery always happened in line with best practice.
- WHO audit forms, when completed, were audited in recovery. Recent data indicates that for the four months prior to our inspection, compliance with the WHO surgical safety checklist was between 90 and 95%.
- We saw that theatre checklists were properly completed for patients going to theatres.

Are surgery services effective?

Good

The unit practiced evidence-based care and treatment. There were excellent audit results for patients treated for fractured neck of femur and theatres operated to best practice guidance. Enhanced recovery protocols were in place for some colorectal and vascular surgery. People were assessed to find, and given pain relief in, a way best suited to them. They also received appropriate assistance with nutrition and fluids.

Staff received support in their work and were supported to undertake further training. Junior doctors reported that learning within orthopaedics was good. Patient outcomes were monitored and audited and there was comprehensive use of a safety and quality dashboard to measure this. The multidisciplinary team worked effectively to manage patient care and a number of services were provided seven days a week.

We did not re-inspect this aspect of the service in February 2015.

Evidence-based care and treatment

- The service treated fractured neck of femur patients in line with NICE guidance and had excellent audit data for this group of patients. The latest data showed that recently all patients were treated within 36 hours, according to best practice.

Surgery

- The emergency surgery theatres followed guidance in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- Other guidance and best practice included guidelines in monitoring unwell and deteriorating patients and the use of care bundles. For example, the sepsis care bundle was initiated when a patient scored a four on the track and trigger warning system.
- There were enhanced recovery protocols in place for some colorectal surgery and were about to commence for patients undergoing vascular surgery (carotid endarterectomy).
- The hospital was now taking part in the national emergency laparotomy audit.
- Staff followed local policy and procedure for the management of falls and pressure area care.

Pain relief

- Pain relief assessments were completed preoperatively, as part of the preoperative assessment process.
- Patients were seen regularly on the unit by senior staff and assessed for pain. We saw that pain relief was administered in a number of ways, such or oral tablets, injection or patient-controlled analgesia, dependent on the best method for the patient. Patients requiring epidural were required to be nursed in an intensive therapy unit (ITU) or HDU bed and could not be nursed on a ward. Staff told us this was due to a lack of level 1 beds.
- We saw staff discussing pain medication with a doctor, as they were concerned that the patient's pain was not being adequately controlled post-surgery. We saw this matter was given a high priority by the clinical staff.
- One senior manager (the clinical director) told us that there was no dedicated acute pain service. Ward staff told us they were well supported by outreach and the medical teams/anaesthetist in managing pain.

Nutrition and hydration

- Where patients were able to eat and drink, we saw that they were supported to do so. We saw one nurse assisting a patient to drink. Audit data showed that people who required their food intake monitoring were commenced on food charts.
- Staff told us that they were able to get support and refer people to the dietician and speech and language therapist if that was required.
- Following surgery, patients' hydration needs were met with intravenous fluids, if required. Other forms of feeding were also managed, including percutaneous endoscopic gastrostomy and total parenteral nutrition.

Patient outcomes

- The unit directorate had a safety and quality dashboard (SQD) that was audited monthly and results were available in public areas of the ward. Safety and quality matters were regularly discussed at team meetings.
- The hospitals had no surgical mortality outliers at the time of the inspection.
- The directorate completed national audits for the work undertaken in surgery.
- Audit results for fractured neck of femur showed that people were treated quickly and the length of their stay reduced.
- Instigation of enhanced recovery packages should improve outcomes and reduce length of stay for these patients.

Competent staff

- The staff survey showed that some staff, across the trust, were not receiving appraisals or supervisions. We spoke with staff, who told us that they had received appraisals in the last year and that this had been an improvement on a year ago. We spoke with ward managers, who confirmed a rolling programme of appraisals.
- Professionally registered staff were supported to maintain their continuous professional development for registration with their professional bodies, through training, reflective practice and education.
- The surgical unit supported staff to undertake further training and education. We spoke with nurses who were 'sign off' mentors for students and who had completed this training while working on the unit.
- We saw that deanery data was in line with expectations with respect to the junior doctor's training. In orthopaedics, data was positive about regional learning for orthopaedic trainees.
- Theatres had a dedicated education and training coordinator to support staff with their training needs.

Multidisciplinary working

- The multidisciplinary team (surgical team, ward nurses, specialist nurses and Allied Healthcare professionals) undertook a ward round daily with input from other disciplines, who regularly attended the round.

- Some formal multidisciplinary team meeting took place with other hospitals, to ensure continuity of treatment for people with certain conditions, such as cancer.
- All patients on the ward were screened by the occupational therapist and physiotherapist to ensure patients who required their input were seen promptly and a plan of care made. We saw that referrals were made to outreach, to specialist nurses and Allied Healthcare professionals, if patients required specialist input.
- In theatres, the multidisciplinary team held a daily trauma meeting to discuss patients for that day's trauma list.

Seven-day services

- There was medical and anaesthetic support out-of-hours. Staff told us that Allied Healthcare professionals were available for the unit at weekends.
- Senior medical staff reported that they were able to get routine radiology services out-of-hours and at weekends.
- Other, specialist staff, such as microbiology and pharmacy, were available, if required, and there were also on-call arrangements for these services, should they be needed.

Are surgery services caring?

Good

We saw staff providing compassionate care, maintaining people's dignity and privacy. Patients we spoke with were positive about the care and attention they had received while an inpatient. Patients were involved with their care and we saw examples of where they had been consulted in major decisions. Staff provided emotional support for patients and their relatives and carers. People with differing spiritual and religious needs could see a representative of their choice. The surgical wards performed well on the NHS Friends and Family Test.

We did not re-inspect this aspect of the service in February 2015.

Compassionate care

- We saw patients being treated with dignity and respect. Curtains were drawn to maintain people's privacy and dignity. Staff told us that if patients were unwell, wherever possible, they were moved to side rooms so that the patients and their family had a greater degree of privacy.
- We saw a patient being assisted to walk by a member of staff. The member of staff spoke with kindness to the patient, did not rush them and gently encouraged the patient, who clearly responded positively.
- We heard a doctor address a patient in the corridor and asked them what they liked to be called, spoke to them respectfully and moved them to a bed space in order to have a private conversation.
- All patients we spoke with had very positive experiences on the surgical wards and spoke highly of all the staff that had cared for them.
- The NHS Friends and Family Test results were positive for the surgical and orthopaedic wards at Pilgrim Hospital.
- In the endoscopy suite, we saw that patients' dignity and privacy was maintained by separate changing facilities being provided and that changing facilities opened directly into the suite. This meant that patients were not required to walk around open areas when preparing for endoscopy.
- Patients had call bells in reach and staff were attentive when it came to answering bells.

Patient understanding and involvement

- Patients had signed consent forms for procedures. Consent forms clearly described the risks and benefits of the procedure. Preoperative notes demonstrated that people had been given options about their care and recovery.
- We saw one DNA CPR form being discussed with the patient, who had been able to have direct input to their care.
- Detailed information was available for patients to take away about their procedure and what to expect. They were given contact numbers of specialist nurses to ensure they had adequate support on discharge.

Emotional support

- Staff told us how they supported patients and their carers during their stay in the unit and emphasised a collaborative approach to care.
- We saw that intentional rounding was carried out to provide care and support for patients staying on the unit.

- We saw information available for counselling services in some clinical areas and some patients were invited to support groups for people who had certain diseases or who had undergone surgery.
- Patients' relatives and carers were able to stay on-site in dedicated rooms.
- A chapel was available for patients if they wished to attend and a chaplain and other faith representatives could be contacted if required.

Are surgery services responsive?

Requires improvement

There were over 600 cancelled operations for the hospital over the last year, with the majority being because there were no beds available. Senior medical staff were concerned about the number of HDU beds, particularly as all patients with epidural analgesia required one. In 2014, data from NHS England for February 2014 showed that general surgery and orthopaedics were missing their 90% referral to treatment time target, so this requires improvement. In 2015, we saw that referral to treatment times were still not meeting national targets for specialities and operations being carried out at Pilgrim Hospital, Boston.

There was an innovative project in place to support people with dementia while they were in hospital. We saw that people's complex needs were well planned to allow for a safe discharge. The hospital actively engaged with some patients to receive feedback on the quality of the care they were providing, and this resulted in changes made to the way the service was run. For people who spoke a foreign language, interpretation services were in place. Staff told us how they managed complaints, and responded to concerns.

Service planning and delivery to meet the needs of local people

- The unit accepted a mixture of elective and emergency general surgery, emergency and elective orthopaedic patients and other specialisms, including vascular surgery.
- Service reconfigurations meant that some surgical procedures were no longer available at Pilgrim Hospital (or across the trust). In an emergency situation, patients would be stabilised and transferred to the appropriate specialist centre in line with local agreements. Some outpatient services were available locally for these patients, but treatment was managed elsewhere.
- There were a number of cancelled operations at Pilgrim Hospital. Data we received showed over 600 operations had been cancelled between April 2013 and the time of our inspection (against 1,100 operations for the trust as a whole). Cancellations were for a number of different reasons, but the largest group were cancelled because of a lack of ward beds. A small number were cancelled because of a lack of HDU beds. Others were cancelled because of clinical reasons, or the patient did not attend for their operation.
- In 2015, the hospital was still performing worse than the national expectations with regards to cancelled operations. There had also been a higher than expected amount of people during that timeframe who had not had their operations rebooked within 28 days. However, it was acknowledged that the trust had a particularly difficult Winter period, with greater than anticipated demand.

Access and flow

- Bed occupancy for the trust was 82.3%, against an England average of 85.9% Patients were assessed by the multidisciplinary team, including an anaesthetist, prior to admission. This allowed staff to highlight patients' care needs before their operation and have plans in place for their recovery.
- Discharge planning began at preoperative assessment stage for elective patients and on admission to the unit for trauma or emergency patients.
- Following audit, all patients with fractured neck of femur were admitted and received treatment within 36 hours, as per national guidance.
- In 2014 the trust was not meeting referral to treatment times (treatment within 18 weeks) for inpatient general surgery at 85.6%, and trauma and orthopaedics at 72.3%, against a target of 90%; meanwhile 94.3% of urology patients were seen within 18 weeks. These figures were for February 2014 and produced by NHS England. In 2015, the last three months of available data (September, October and November 2014) showed that other than on one occasion, the trust continued to fail to meet referral to treatment time targets.
- Patients who required an epidural following surgery were routinely cared for in HDU or ITU, as the ward did

not accept these patients. We were told that this was due to a lack of level 1 beds. In 2015 we were told that although patients requiring epidural analgesia required an HDU bed, plans were in place to care for these patients on the ward.
- Staff reported that it was uncommon to have surgical outliers on other wards at the hospital, and that it was more common for surgical wards to have medical outliers.
- If patients in day surgery were assessed as being unfit for discharge, they were transferred to the ward to ensure that they received the correct care.

Meeting people's individual needs

- The unit provided support with additional needs, such as those required for bariatric patients. Pressure-relieving equipment was available and staff reported no problems in accessing the equipment.
- The hospital was piloting a new position, that of dementia support worker. Their role was to support people with dementia and their relatives while in hospital and help facilitate a seamless discharge for dementia patients. They undertook work to help dementia patients settle in an unfamiliar environment.
- Interpretation services were available for people who required support with communication, and was available by telephone. Shortly before our arrival, a patient on the ward was clerked and admitted to the ward by using interpretation services.
- Staff were aware of the needs of people from different faiths and religions and that representatives of other faiths could be contacted to meet people's spiritual needs.
- We saw that, where people needed ongoing support, the wards were able to refer to other agencies or complete assessments for ongoing support.
- A patient with complex needs was being prepared for discharge. They had been assessed as being at a high risk of falls. A falls alarm had been arranged for their home and they had been referred to the appropriate community professionals to continue to manage their care.
- Falls had been reduced in orthopaedics from seven in one month to one. This was achieved by accurate assessment and one-to-one care for high risk patients.
- Graphics above each bed in orthopaedics gave staff a quick reference as to how much assistance people needed to mobilise.
- In theatre recovery there was a dedicated paediatric bay that allowed for some privacy for child patients and this allowed their parents to be in attendance.
- Patients who had had colorectal surgery were invited back to the hospital as a group to feedback their experiences. These were well attended and resulted in changes to discharge processes and information given to patients.

Learning from complaints and concerns

- Complaints were handled in line with the trust complaints policy and the new Patient Advice and Liaison Service team. Information on how to make a complaint was available for patients and carers.
- Outcomes and actions from complaints were disseminated to staff through formal and informal meetings. We spoke with a senior nurse, who told us of the actions taken following a complaint and the changes that had been made.

Are surgery services well-led?

Good

Staff reported that there had been significant positive change in the last year and felt that at directorate and ward-level they were moving in a clear direction. We spoke with staff, who were proud of the quality of care they provided and were clear of their department and the Pilgrim Hospital's values.

We saw that safety and quality governance was taken seriously at all levels. The culture within the service was positive and open. Staff spoke highly of their ward and department leaders and said that the executive team were now more visible than in the past. Staff felt they worked well as a team and were supported in their work. We were told that Listening into Action had delivered tangible results, such as reduced recruitment times for new staff, and the 'plan for every patient' was an innovative way to ensure all patients were holistically assessed.

We did not re-inspect this aspect of the service in February 2015.

Vision and strategy for this service

- All the senior nurses we spoke with in the directorate told us that the service was moving forward after a difficult period.

Surgery

- We saw that the trust values and vision were placed around the clinical and non-clinical areas of the hospital. Staff we spoke with told us that they were aware of the values of the trust.
- At a ward-level, staff spoke positively of their ward leaders, telling us that they had a vision of where the ward was moving to and the surgical directorate as a whole. Change had been affected quickly in some areas and staff felt this positive change was already having an impact on the service.
- We met staff on the endoscopy suite, who were clearly proud of their work and the high level of care they provided to patients and their carers. They had a clear understanding of the values of the unit and were united with the management's vision in taking the service forward.

Governance, risk management and quality measurement

- The unit leadership, both nursing and medical, had completed audits designed to measure the quality of the measurement. Safety and quality dashboard audit data went beyond data captured by the Safety Thermometer.
- Senior medical staff told us that junior doctors were encouraged to undertake service improvement work.
- The surgical directorate had monthly governance meetings, where risk and service improvement were discussed. However we did not see evidence that medication errors had been addressed.

Culture within the service

- Staff told us that the manager of the service and senior medical staff were visible and approachable on the unit.
- The executive team, board members and senior management were more visible in clinical areas than they had been in the past.
- Unit-level staff survey data was not available, but we saw the results for the most recent staff survey (2013). The trust performed within the bottom 20% of trusts nationally for questions relating to effective team-working and work pressure, amongst other indicators. Staff we spoke with at Pilgrim Hospital were broadly positive about team-working and that the increased number of staff had helped significantly with this.
- Staff told us that they received appraisals and attended team meetings, as well as being supported to develop their role by undertaking further education and training.
- The culture supported staff in raising incidents or concerns. The unit was open and transparent about incident reporting and staff we spoke with said they felt able to raise concerns and were confident in their positions.
- Across most of the surgical directorate, sickness ratings were falling though rates of senior medical staff sickness were persistently high in some areas, such as theatres.

Innovation, improvement and sustainability

- Staff told us that staffing was more sustainable than previously. Staff reported that Listening into Action had been successful at the trust and had resulted in improvements, such as streamlined recruitment strategies.
- The 'plan for every patient' was in place. This ensured all patients were properly assessed in a timely way by the multidisciplinary team. This ensured a smooth transition to discharge.

Critical care

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

Information about the service

Boston Pilgrim Hospital ITU is funded for nine critical care beds and sometimes opens one further bed. The unit provides care for a mixture of people requiring level 2 and level 3 care for a medical or surgical condition.

We spoke with five members of staff on the unit and spoke to two staff at focus groups. We observed care in the main unit and reviewed information available.

Summary of findings

The service was safe and effective, the unit was clean and care was provided in line with national best practice guidance. There were audits in place that demonstrated care and treatment was provided in line with expected parameters.

We saw staff providing compassionate care and maintaining people's dignity and privacy. There was positive interaction between staff and patients and their relatives.

The service was responsive to patients' needs. The unit was sometimes required to open an additional bed to meet demand for higher level care. Access and flow was managed through the unit. There were low levels of readmissions to the unit, or transfers out to other hospitals. The unit was able to care for patients requiring specific support, such as bariatric patients and those requiring interpretation services.

The service was well-led. The ward manager demonstrated a clear vision for the service and was passionate about the care their unit provided. Staff said they felt supported by nursing and medical colleagues at a local level and that in the last year, senior management had become more visible.

We did not re-inspect this service in February 2015.

Critical care

Are critical care services safe?

Good

The ITU provided safe care to people who used the service. There had been one recent serious incident and this was being investigated at the time of our inspection. The unit was clean and data showed that infection rates were within acceptable limits. There had been no recent MRSA bacteraemia or C. difficile infections. PPE was available for people working in and visiting the unit. Records were electronic and managed and completed correctly to ensure continuity of care provision.

Staff had received mandatory training and also had received additional training for working in a specialist environment. Staff demonstrated safe medicines management and were aware of their responsibilities under the Mental Capacity Act 2005 and for safeguarding. There was adequate medical cover for the unit both in and out-of-hours. Nursing staff numbers were planned on the unit having nine beds open (a mixture of level 2 and level 3 beds). Staff were able to manage the deteriorating patient locally or by transfer to other Critical Care Units to facilitate safe care and the outreach team supported other clinical areas in managing the deteriorating patient.

Incidents

- Information available to us showed that there had been eight serious incidents reported for critical care, anaesthesia and pain management across the trust.
- There had been one recent serious incident shortly before our inspection. We spoke with the senior nurse in charge. They described a robust reporting procedure and a thorough investigation of the incident. Though the investigation had not been completed, they told us of the likely actions that would be taken to ensure the incident did not happen again. The actions were proportionate and clearly designed to mitigate future risk. The senior nurse told us that the clinical practice response to the incident would be cascaded to staff.
- Staff we spoke with at focus groups and on the Critical Care Unit confirmed that they always received feedback on incidents and complaints and what actions to take.
- Staff understood the mechanisms and importance of reporting incidents within the department.

Cleanliness, infection control and hygiene

- Information from the ICNARC Case Mix Programme audit (an audit of patient outcomes from adult, general critical care units) and provided by the trust, showed that infections of MRSA and MSSA were within statistically acceptable limits. ICNARC data showed there had been no recent unit-acquired MRSA bacteraemia infection.
- The ITU appeared clean. We saw staff regularly wash their hands between patients and interventions and alcohol gel was also available.
- PPE was readily available to staff. PPE was also available to visitors if they required it when visiting.
- Single use equipment was used to prevent cross infection, for example, tourniquets.
- There were gowning lobbies between side rooms to prevent cross infection.

Environment and equipment

- The environment on the unit was safe, with sufficient space for the safe movement of patients, staff and visitors. The unit had been comprehensively remodelled and refurbished in 2012, ensuring sufficient space and correct layout to monitor very sick patients.
- Side rooms were available, if required. Again, there was sufficient space to ensure safe movement of patients who may require the use of lifting equipment, such as hoists.
- Equipment on the unit was clean and maintained at regular intervals as instructed by the manufacturer.
- The resuscitation equipment was checked daily and other specialist equipment such as ventilators was checked at handover of shifts.
- Daily safety checklists of the equipment were completed.

Medicines

- Medicines were stored correctly and secured where necessary.
- Fridge temperatures were checked daily to ensure medicines were properly stored.
- We saw staff double-checking medicines correctly prior to administering them to a patient.
- The medicines room was locked and only accessible via a swipe card carried by members of staff. As a further precaution, only members of staff who had been trained and deemed competent to administer medicines were able to access the medicines cupboard.

- Medicines were prescribed using the electronic patient records system. This acted as a check on prescribing and also allowed staff to quickly check prescribing histories.
- Staff told us that they had some problems in accessing commonly-used medicines for ITU. For example, they told us that, recently, they had waited five days from point of order for prefilled insulin syringes (used to manage patients' diabetes) and they had also waited several days for a common (stock) antibiotic. Though this had not impacted on care, they were concerned for the potential for impact in the future.

Records

- The ITU used electronic documentation different to ward areas, as is common in critical care units.
- Records were electronic and an integrated software bundle was used to manage a variety of patient interventions. For example, blood results and observations (blood pressure, pulse and so on) were connected to the system, so that staff had quick access to results. Results requiring attention were highlighted on the system. All prescribing was completed on the system, as were free text nursing, medical and Allied Healthcare observations.
- The electronic records system contained all relevant risk assessments and could highlight when these had not been completed or when they were due to be reviewed.
- All staff had access to the patients they were caring for and the electronic login meant there was a record of which staff had accessed records.
- Staff we spoke with told us that single documentation made for reliable and quick information sharing. They told us it had been a significant improvement on the paper-based system, that information was more easily cross-referenced and there was no danger in member of staff walking off with the notes. This ensured patients' notes were always available to staff treating patients.
- Though patient information was easily accessible to staff, confidentiality was maintained. For example, the screen could be tilted away from any other people in the room.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that people had signed consent forms prior to surgical or medical intervention. They detailed the risks and benefits associated with the procedure and were signed by the patient.
- A training matrix we saw in the manager's office showed that staff had had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguarding.

Safeguarding

- Staff had received mandatory training in safeguarding. Staff we spoke with were aware of the procedure, should they be concerned about a safeguarding issue, as well as how to contact the safeguarding team.

Mandatory training

- The majority of staff had received, and were up to date with, mandatory training, including: moving and handling, basic life support and infection control.
- The ITU supported staff to develop and enhance their clinical skills by undertaking degree-level courses in Critical Care nursing.
- The unit benefitted from a clinical education (senior) nurse working on the unit. They ensured that staff were up to date with training and developed bespoke training for the unit.

Management of deteriorating patients

- Critical Care provided an outreach team to the wards for seven days a week during the day, usually by visiting the patient on the ward. The team could escalate concerns to the intensivist who would review all patients prior to admission to ITU. Out-of-hours, the support was provided by the Hospital at Night team.
- The outreach team told us that, previously, cover of outreach had been patchy, but had significantly improved in the last year. They told us they could still see up to 18 patients a day on the wards.
- Staff we spoke with on the wards said they felt well supported by the outreach team, who responded quickly in the event of a referral based on the patients' track and trigger score.
- The ITU was able to manage a significant majority of their patients. As they had level 2 and level 3 beds on the unit, they were able to increase the level of care a patient received without transferring them to other hospitals. The Mid Trent Critical Care Network showed a small number of clinical transfers.
- On occasion, that patients required further specialist care, then patients were transferred to the most appropriate unit. This was actively managed and facilitated by the unit's involvement with the Critical Care Network.

Critical care

Nursing staffing

- The ITU was staffed for nine beds, five of which were level 3 and four were level 2. Staffing was arranged as one nurse to one patient in level 3 beds and one nurse to two patients in level 2 beds. Nursing staff were supported by senior nurses not allocated to individual patients and by healthcare support workers. Staff told us that they could open one further bed in the event of an emergency and that these were staffed by bank or staff doing overtime. During busy periods, staff on the unit may have to manage additional patients until further cover could be arranged.
- Staffing was maintained for the nine beds on the unit throughout the day. Staff we spoke with told us that, sickness aside, staffing numbers were maintained and that staffing had improved in the twelve months prior to our inspection.
- Staffing levels on the unit were close to establishment, allowing flexibility with staffing and the skills mix.
- The unit, at times, used bank and agency staff to support staffing numbers. We were told that predominantly, in house bank staff were used to cover shifts, as this ensured continuity and safety for patients.

Medical staffing

- The consultant intensivists and registrars for the unit worked a full rota. This meant the unit received the same level of cover throughout the day and out-of-hours, such as overnight and at weekends. Medical staff reported an occasional lack of junior doctors on the unit, but were well supported by middle grade staff.
- All intensivists had received specialist Critical Care training.
- Senior nursing staff we spoke with told us that the consultant reviewed patients prior to admission (where possible) and would always review a patient, if requested. The outreach team confirmed this.
- Staff told us that there were no renal doctors on-site and that patients had to be transferred to Lincoln County Hospital for dialysis.
- The consultant to patient ratio was within acceptable limits and did not exceed one to 14.

Are critical care services effective?

Good

The unit used evidence-based care and treatment in line with best practice. The unit was a member of the local Critical Care Network, sharing best practice and ensuring patients were looked after in the correct facility. Intensive Care National Audit and Research Centre database (ICNARC) data, showed no outliers for the unit. Readmissions were low and there had been 11 cancelled operations due to lack of critical care beds in the last quarter of 2013. Patients were given pain relief in a way best suited to them and their condition, as well as receiving adequate fluids and nutrition.

Staff received appraisals and were supported to keep up to date with clinical practice and undertake higher education in specialist nursing. The multidisciplinary team worked well together, though there appeared to be a lack of pharmacy support on ward rounds, to provide effective, holistic care to patients. Most services were available seven days a week.

Evidence-based care and treatment

- The ITU used national guidance (such as NICE) to determine care provided. We saw that the unit was actively engaged with the Mid Trent Critical Care Network and shared best practice with other critical care units. This included the sepsis critical care bundle from the network.
- We saw that many procedures were standardised throughout the network, so that care was provided in line with best practice and was consistent.
- Senior staff told us that they updated their team at team meetings of any changes to guidance that would impact on the care they were providing. We saw minutes of a previous team meeting that showed items regarding changing practice were discussed with staff.
- We saw that the unit carried out audits regularly and results were posted prominently throughout the unit.
- The unit contributed to the ICNARC, which showed no outliers for the unit.

Pain relief

- Patients were seen regularly on the unit by senior staff and assessed for pain. We saw that pain relief was administered in a number of ways, such or oral tablets, injection, PCA or epidural, dependent on the best method for the patient.

Nutrition and hydration

- Where patients were able to eat and drink, we saw that they were supported to do so.

- For patients unable to eat and drink, nutrition and hydration was supported by other means, such as intravenous fluids or percutaneous endoscopic gastrostomy (PEG) or total parenteral nutrition (TPN).

Patient outcomes

- The unit took part in a clinical audit, specifically the ICNARC.
- ICNARC data indicated that there had been one unplanned readmission to the unit in the first quarter of 2014.
- Mortality data suggested that the unit was within expected mortality rates. For January to March 2014 the SMR was 0.85%.

Competent staff

- The staff survey showed that some staff across the trust were not receiving appraisals or supervisions. We spoke with staff, who told us that they had received appraisals in the last year and the unit manager confirmed that. However, we spoke to one senior nurse, who told us that they had not had an appraisal for four years. They believed this was due to a change in their direct line manager.
- Professionally registered staff were supported to maintain their continuous professional development.
- The clinical education nurse took the lead for ensuring staff were properly skilled and educated for their role. We saw documentation relating to a comprehensive induction programme for new staff, which included a six week supernumerary status. Staff completed an annual competency checklist and we saw how this had been developed to reflect changes within the unit. There was a further competency development programme, allowing staff to develop their skills in line with their experience.
- The unit regularly supported staff to undertake the critical care nursing course at a local university.
- Staff received mentoring across the unit to ensure they had somewhere to go with any questions.

Multidisciplinary working

- The local multidisciplinary team undertook ward rounds, which included medical, nursing and Allied Healthcare staff. This daily ward round was also completed at weekends and further specialist support was available.
- Staff brought to our attention that pharmacy staff did not often complete ward rounds with the multidisciplinary team. They said that, though they had a good relationship with the pharmacist, they believed a lack of pharmacy presence contributed to issues with medicines ordering and management.
- Physiotherapy staff assessed patients early in their stay on the ward, to plan rehabilitation needs.
- More widely, the Critical Care Network provided a supportive multidisciplinary team and was essential for transferring patients requiring specialist care.

Seven-day services

- Medical and nursing staff were available on a full rota in and out-of-hours.
- Allied Healthcare professionals provided care and support throughout the weekends.
- Other, specialist staff, such as microbiology and pharmacy, were available by telephone if their input was required.
- Staff told us they were able to get routine radiology services out-of-hours, as well as urgent scanning.

Are critical care services caring?

Good

We saw staff providing compassionate care, maintaining people's dignity and privacy. There were positive interaction between staff and patients and their relatives. Patients were kept informed of their treatment and their future plan of care where possible, but staff described how, in these circumstances, they liaised closely with relatives and carers. There were pleasant facilities for relatives and carers to have conversations with medical and nursing staff, away from the ward. The NHS Friends and Family Test were positive for the unit

Compassionate care

- We saw patients treated with dignity and respect. Curtains were drawn to maintain people's privacy.
- Side rooms offered a degree of further privacy. Shortly after we entered the ward, staff pulled the curtains in a side room to protect their privacy.
- We saw one person who was awake. A member of staff interacted with them in a genuinely caring and compassionate way. Staff told us that it was possible to build a good rapport with some patients if they were on the unit for some time.

- We saw that for patients who were awake, the bed was turned to the window to allow them to benefit from the view and orientation to time and place.
- The NHS Friends and Family Tests were positive for the unit.

Patient understanding and involvement

- Due to the nature of the unit, patients could not always be directly involved with their care, but staff explained how they managed this by talking to relatives and carers to keep them up to date.
- For patients who were awake, staff sought their permission before undertaking interventions.

Emotional support

- Staff told us how they supported patients and their carers during their stay in the unit.
- People were given information regarding their care and the support available both in and outside of the hospital.
- A hospital chaplain was available and staff could access representatives of other denominations and faiths if patients or carers required it.
- A comfortable room was used for discussion with relatives, which gave them time and space away from the clinical area.
- Staff explained how they were able to operate longer visiting for relatives of unwell patients and that accommodation was available on-site for people who wished to stay over.

Are critical care services responsive?

Good

The unit was sometimes required to open an additional bed to meet demand for higher level care. Access and flow was managed through the unit. There were low levels of readmissions or transfers out in the most recent period. The unit sometimes had delays in discharging patients to the wards and staff said this was usually because of a lack of beds. When patients were transferred, the ward were given copies of their ITU records so that patients' individual needs could be met.

The unit was able to care for patients requiring specific support, such as bariatric patients and those requiring interpretation services. Patients were cared for in appropriate facilities and the unit demonstrated how it learned from complaints and concerns, including serious incidents.

Service planning and delivery to meet the needs of local people

- The unit was staffed for nine beds, but on occasion it was necessary to open additional beds. Staff told us that they staffed the beds by predominantly bank and overtime staff to ensure adequate staffing provision. Staff told us that, in cases of emergency, they occasionally had to look after more patients than they were staffed for, but this was for short period only. There was a plan in place to close the escalation bed safely, by transferring patients who no longer required the higher level of care or by transferring patients who required further specialist care to other critical care units.

Access and flow

- Critical care bed occupancy across the trust was 81.7% compared to 81.4% nationally. The ITU bed occupancy was stable at around 80% between May and December 2013. The occupancy figures were combined figures of the level 2 and level 3 beds. The Royal College of Anaesthetists (RCA) makes recommendations for occupancy levels in level 3 beds of 70%, but makes no recommendation for occupancy levels in level 2 beds.
- We were told that two level 2 beds were used for pre-planned (elective) surgery.
- For the final quarter of 2013, the unit had one non-clinical transfer out and one readmission. A low level of readmission is indicative of correct treatment and discharge plans. A unit of below 5% readmissions, such as this, is considered to be performing well, according to RCA.
- For the same period there were 15 out-of-hours discharges and 11 cancelled operations because of the lack of a critical care bed.
- The average delay for patients who no longer required a critical care bed and needed transfer to a ward was 12 hours. The target is four hours. Staff told us that the lack of availability of ward beds was the main reason for delayed discharge. The senior nurse told us that they conducted a monthly delayed discharge audit to monitor the situation.

Critical care

Meeting people's individual needs

- The unit provided support with additional needs such as those required for bariatric patients and people with disabilities.
- Interpretation services were available for people who required support with communication, and was available by telephone.
- The unit found that, on discharge to the ward, ward staff would not be in possession of all the patients' notes, as they had been electronic. The unit had changed its practice and now sent a comprehensive paper copy of the patients' notes, including their ongoing individual needs, to the ward when the patient was transferred.
- The senior nurse told us that there were no patient call bells on the unit. They had been told it would not be possible to retrofit these to the new unit. To mitigate this, risk assessments had been completed and staff deployed to ensure safety.

Learning from complaints and concerns

- Complaints were handled in line with the trust complaints policy and the new Patient Advice and Liaison Service team. Information on how to make a complaint was available for patients and carers.
- Outcomes and actions from complaints were disseminated to staff through formal and informal meetings. We were told that there had been no recent complaints to the unit.
- The unit held a yearly patient experience event where patients could discuss their experiences and the unit could adapt to make changes. There were also patient experience clinics run three months after discharge from the critical care unit.

Are critical care services well-led?

Good

The ward manager demonstrated a clear vision for the service and was passionate about the care their unit provided. Staff said they felt supported by nursing and medical colleagues at a local level and that in the last year, senior management had become more visible. The unit worked well with other wards and departments within the hospital and critical care units in other hospitals. While performance on the staff survey in 2013 had been poor for many questions, all staff we spoke with told us that things had improved in the last year. Staff were supported to undertake further training, including the unit manager, and staff we spoke with at focus groups felt local management was approachable. The unit had implemented a novel software package, enabling a paperless unit in which information was shared promptly.

Vision and strategy for this service

- The ward manager demonstrated a clear vision for the future of the service. The manager was clearly passionate about their critical care unit and how it supported the wider hospital and trust. Staff we spoke with at focus groups told us that they felt their work place was forward-thinking and they knew the direction of travel for the unit.

Culture within the service

- Staff told us that the manager of the service and senior medical staff were visible and approachable on the unit.
- Unit-level staff survey data was not available, but we saw the results for the most recent survey (2013). The trust performed within the bottom 20% of trusts nationally for questions relating to effective team working and work pressure, amongst others. All staff we spoke with on the unit and at focus groups told us that things had improved in the last year and that board-level managers were now more visible.
- The unit provided an outreach service to other parts of the hospital. Staff told us that they worked well with other departments and wards within the hospital and, through the Critical Care Network, neighbouring trusts.
- The culture clearly supported staff in raising incidents or concerns, as evidenced by the recent serious incident. The unit was open and transparent about the incident and proactive in changing practice to ensure safe care.
- Staff told us that they received appraisals and team meetings as well as being supported to develop their role and undertake further education and training. We saw evidence that meetings were held and staff encouraged to attend and

Innovation, improvement and sustainability

- The critical care unit had been at the forefront of the trust in developing a truly paperless unit. It had engaged with partners both inside and outside of the organisation to implement the system to the benefit of patients. The system was under constant review to ensure it was fit for purpose and responded to changes in critical care.

Critical care

- The clinical education nurse had implemented training and support packages for staff to ensure the sustainability of the unit through a comprehensive skills mix and fostered a culture of continuous improvement.

Maternity and family planning

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

Information about the service

The Pilgrim Hospital site at Boston provides a full range of maternity services. In 2013, there were 2,047 births recorded.

The Pilgrim Hospital provides care and treatment for women with low and high risk pregnancies and provides care during their antenatal, intrapartum and postnatal period. However, the Pilgrim Hospital is unable to provide care to women with very complex pregnancies or births below 34 weeks gestation.

In addition to maternity services being delivered at this location, there are also teams of community midwives and Maternity Care Assistants (MCA) who deliver antenatal and postnatal care in women's homes, clinics and general practitioner locations across the county of Lincolnshire, as well as supporting women to give birth at home. Last year, between two and 2.85% of women experienced a home birth.

In 2014 we spoke with 63 members of staff, including doctors, midwives, student midwives, maternity support workers and administration staff. We also spoke with six women who used the service and two family members.

In 2015 we spoke with 24 members of staff, including doctors, midwives, student midwives, maternity support workers and administration staff. We also spoke with seven women who used the service, and two family members.

Summary of findings

In 2014, the trust had reported two similar 'never events' within 12 months. Action taken following the first 'never event' had not been embedded into practice, monitored and reviewed to prevent recurrence of an unacceptable event. In 2015, we found ongoing safety improvements at the maternity unit at Pilgrim Hospital. The risk management and incident reporting practices had been developed since the last inspection in May 2014. The risk system was more robust, and communication around risks was improving across the trust, as well as the directorate, to ensure that lessons were learnt and practice changes embedded.

In 2014, significant environment risks had been identified, but no substantial risk control had been put into place at the time of our inspection. In 2015, the trust were taking appropriate steps to address the key concerns. The trust had previously identified the presence of asbestos in the maternity building as an environmental risk, and had introduced substantial risk controls since our previous inspection in May 2014. The Health and Safety Executive were in the process of approving and closing the improvement notices, as the trust were showing that adequate risk controls regarding the presence of asbestos were now in place.

Clinical effectiveness was embedded in practice, and all policy and standards were evidence and research-based. The provider had robust systems in place for the ratification of new policies and guidance. We saw improvements in the maternity dashboard,

Maternity and family planning

which represented how national indicators were measured to show the responsiveness of the unit; however, it was not clear how patients were informed of these indicators.

All the women we spoke with told us that they were happy with their care, and were involved in the planning of their care and treatment.

In 2014, there were no specialist midwives for bereavement, substance misuse or safeguarding. At our inspection in February 2015, we found that funding for a substance misuse specialist midwife has been requested as part of CQUIN for 15/16, and there is further consideration for developing the specialist midwife roles across the trust, which is noted as work in progress.

In 2014 we found that there were no facilities available for women with low risk pregnancies and labours to have their babies in a midwifery-led unit or to access a water birth, though these facilities were under construction. In 2015, we found improvements had been made to review and develop maternity services at Pilgrim Hospital, such as the introduction of a new unit to house maternity services, which is due to open in October 2015, and the provision of a birthing pool to provide women with more choice at time of delivery.

In 2014, we found that there was no formalised system put into place to ensure that the head of midwifery post was temporarily covered until a replacement head of midwifery could be employed. In 2015 we found that a new head of midwifery (HOM) had been appointed across the trust in August 2014. Staff were positive regarding the current leadership, and the strong focus on governance, staffing and risk management since this appointment. In response to the previous inspection findings in May 2014, the maternity unit was currently reviewing work planning, clinical performance and governance score cards, in line with national guidelines, to develop the measures for safe practice.

Are maternity and family planning services safe?

Good

We found ongoing safety improvements at Pilgrim Hospital. The risk management and incident reporting practices had been developed since the last inspection in March 2014. The risk system was more robust, and communication around risks was improving across the trust, as well as the directorate, to ensure that lessons were learnt and practice changes embedded.

A new head of midwifery (HOM) was appointed across the trust in August 2014. Staff were positive regarding the current leadership, and the strong focus on governance, staffing levels and risk management since this appointment. In response to the previous inspection findings in March 2014, the maternity unit was currently reviewing work planning, clinical performance and governance score cards, in line with national guidelines, to develop the measures for safe practice.

The current environment was not good, but the trust were taking appropriate steps to address the key concerns. The trust had previously identified the presence of asbestos in the maternity building as an environmental risk, and has introduced substantial risk controls since our previous inspection in 2014. The Health and Safety Executive were in the process of approving and closing the improvement notices, as the trust were showing that adequate risk controls regarding the presence of asbestos were now in place, including maternity accommodation changes, with a planned completion date of October 2015.

Incidents

- There was an effective mechanism to capture incidents, near misses and Never Events. Staff told us they knew how to report, both electronically and to their manager. We saw a robust governance framework which positively encouraged staff to report incidents and information on how to complain was visible to the people using the service.
- We saw that one Never Event had been reported in November 2013. These are events that the Department of Health states must never happen and are unacceptable. We saw that practice had been changed as a result of the Never Event being reported. All of the

staff we spoke with were able to talk to us about the event, what actions had been implemented and the methods used to ensure that the changes were embedded into practice.

- A similar Never Event had occurred twice in 2012 and an action plan had been implemented in August 2012. This meant that, although actions and changes had been made following the two incidents in 2012, this had not been embedded into practice, monitored and reviewed to prevent recurrence of an unacceptable event. During this inspection, we were assured that this had been rectified and current practice had been implemented.
- We asked staff to explain how learning from incidents and complaints was cascaded to all staff. Their responses indicated to us that learning and trends from incidents and complaints was disseminated to staff. We saw evidence that these were discussed in the clinical governance meetings, which were open to all staff to attend. Since March 2014, we saw that the business team compiled a monthly quality report. This meant that staff had access to monthly quality data, which included information on incidents, complaints, patient experience and recent changes to practice. This demonstrated the provider disseminated learning.
- We also saw that a monthly perinatal mortality meeting was held. The head of service explained to us that these meetings were used to present complex cases and were used as a forum for staff to discuss good practice and learn from and improve practice that was less good.
- The risk management and incident reporting practices had been developed since May 2014, when there were concerns that learning from incidents had not been embedded and reviewed to prevent recurrence of an unacceptable event. There had been development of a pan trust maternity clinical risk team, comprising of two band 6 midwives and one band 7 risk manager, to oversee risk practices, and we saw minutes of risk meetings that showed risk registers being updated, the learning from the 'never events' in 2014 discussed, and the risk management structures reviewed, to improve reporting and communication practices.
- A fortnightly incident meeting had been introduced, including a multidisciplinary team and risk midwife to review each incident and feedback to staff, to ensure practice changes and lessons learnt, to reduce the likelihood of reoccurrence. Staff told us that the risk system was more robust and that communication around risks was improving. They knew what was on the risk register, and gave examples of practice changes, such as the introduction of labels, and more robust checking systems to avoid retained swabs.
- The provider reported that lessons learned were incorporated into a monthly report that goes to all specialty governance groups, patient safety, the quality governance committee and the trust board, to ensure learning across the trust, as well as the directorate where the incident occurred.

Safety thermometer

- In 2014 we saw evidence that the Safety Thermometer was undertaken on a monthly basis, and the results displayed for staff to access the performance of each inpatient area. However, it should be noted the areas covered by the monitoring tool, such as number of falls, pressure ulcers and VTE, did not accurately reflect maternity services. A maternity tool is being piloted nationally by the quality observatory.
- In 2015 we saw evidence that the maternity unit was reviewing clinical performance and governance score cards in line with national guidelines, at the governance and risk meetings, to develop the Safety Thermometers, as they were not maternity-focused in 2014. There were also now maternity dashboards, with clinical indicators available for staff reference, which were being developed in line with the Royal College of Obstetricians and Gynaecologists. The head of midwifery (HOM) recognised that there was more work to do in this area, and that this was work in progress to refine the data and improve safety benchmarking.

Cleanliness, infection control and hygiene

- The data we reviewed in 2014, suggested that maternity infection control rates were within a statistically acceptable range. During our inspection, we saw that the environment was clean. However, the majority of staff we spoke with explained to us that they did not have access to a routine domestic service after 12 noon, every day. The staff told us that this meant they relied on the rapid response team should they require an area to be cleaned. In 2015, we found that cleaning support had been extended since 2014, to provide additional domestic support between 12 noon and 3pm in the units. Staff and one domestic spoken with, were happy with this cover, and the support of the response teams, where a more urgent clean was required out of hours. Cleaning standards were satisfactory.

- We saw that a robust infection prevention and control audit programme was undertaken. This included weekly audits, which monitored hand hygiene, the environment, drug prescribing and the use of urinary catheters and cannulas. We also saw an extensive annual audit was carried out between January and March 2014. We spoke with the infection prevention and control lead who also explained that ad hoc "glow and tell" checks were carried out at least once a year on each area. This test shows how well staff wash their hands by using an ultra violet scanner.

Environment and equipment

- We saw in 2014 that the environment was clean and tidy in all the areas we visited. We also saw, and staff told us that an extensive painting and decorating programme had been undertaken. In 2014 we saw a leak in the department. The trust had previously identified the presence of asbestos in the maternity building as an environmental risk. However, no substantial risk control had been put into place at the time of our previous inspection in 2014. The director of estates provided an overview of the current management plan, controls assurance and monitoring arrangements, which were satisfactory, and included risk assessments and advice from an asbestos advisor on risk management. Staff were clear on the risk management practices should a leak occur in the labour ward.
- We saw that the Health and Safety Executive were in the process of approving and closing the improvement notices, as the trust were showing that adequate risk controls regarding the presence of asbestos were now in place.
- We found that the plans for the decant accommodation for levels two and one of the maternity building at Pilgrim Hospital were well advanced, with a planned completion date of October 2015. Estates had consulted with staff regarding the design of the modular units and user engagement was being encouraged through the maternity services liaison committee (MLSC).
- We spoke with staff, and all confirmed that equipment was available, there were sufficient numbers, and that it was well maintained. We also saw that staff undertook daily, weekly and monthly checks of equipment.

Medicines

- During our inspection in 2014, we randomly checked medicines held in the clinical areas. We found the drugs to be stored correctly and in date. We also checked the controlled drug cupboard in the labour ward, and checked the number of controlled drugs against the controlled drug records, and found them to correspond. A weekly controlled drug audit was carried out, and the results were displayed in the clinical areas.
- We spoke with two patients in the antenatal ward, who were waiting for medication before being able to be discharged – both had been waiting for two hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We asked a number of staff if they had attended training on mental capacity assessment and consent. All confirmed they had. One member of staff told us that, should they require further support, they have access to a learning disability lead nurse who supports midwives to assess women's capacity to make informed decisions regarding their care and treatment.
- We reviewed the Women and Children's Division mandatory training figures. The data shared with us was of poor quality. We spoke with a senior midwife, who explained to us that ward managers had a training folder for all staff in the clinical areas. Training attendance was manually checked at ward-level. This meant that we were unable to determine the exact number of staff who had accessed the training.

Safeguarding

- We asked a number of staff to describe the training they had received in relation to safeguarding the vulnerable adult and child. All staff told us they had received the appropriate training.
- We reviewed the Women and Children's Division mandatory training figures. The data shared with us was of poor quality. This meant that we were unable to determine the exact number of staff who had accessed the training.
- In 2015 we found that the HOM was actively recruiting to the safeguarding lead role, which was vacant at the last inspection. There is an established full-time post for a named midwife for safeguarding, which is currently out to advert. This was successfully recruited into in June 2014, but became vacant again in November 2014. Interviews were held in December 2014, but no one was appointed. In the interim, safeguarding is co-ordinated by the three community midwifery co-ordinators, with advice and support from the maternity matrons. The

trust safeguarding team are aware of the vacancy within the maternity service, and there is a named nurse for safeguarding children and young people as the contact point for maternity-related queries.

Mandatory training

- In 2014 we reviewed the women and children's division mandatory training figures. The data shared with us was of poor quality. This meant that we were unable to determine the exact number of staff who had accessed the training.
- We asked a number of staff to describe the mandatory training they had received. Staff told us they had received appropriate training, including safeguarding, obstetric emergencies, infection control, and breastfeeding.
- We spoke with a senior midwife in 2014, who assured us that training was undertaken, but the recording of attendance was poor. They were able to tell us the attendance figures for midwifery mandatory training, trust-wide mandatory training, and the skills and drills training. All were between 90 and 100% attendance. In 2015, staff told us that core learning requirements have been reviewed and reinforced, with compliance managed through monthly performance clinics. Staff were familiar with the booking process, and reminders were given at team meetings. There was e-learning for the Mental Capacity Act and Deprivation of Liberty Safeguards, and safeguarding attendance was up on 2014. The current attendance levels were reported to be 70% core learning, which is improving on 2014, but needs more work to reach target.

Midwifery staffing

- We reviewed the staffing establishment and vacancy rate in 2014, and found the staffing to be adequate to meet the needs of the women using the service. We also saw that the birth ratio was one midwife to 30 women. The recommended national guidelines state that the ration should be one midwife to 28 women. However, we saw that progress was being made to reduce the ratio. One senior midwife explained that due to the recruitment of midwives, the ratio would be reduced to one midwife to 29 women. This was within the national guidelines.
- In 2014, we found that the maternity departments had funding for ten additional midwives across the trust, to facilitate improved birth to midwife ratio, which was currently 1:29 at Pilgrim Hospital. We discussed the ratio of community midwives to women, at 1:30, which is higher than the national guidelines and was raised in 2014 by the Care Quality Commission. It was reported that the HOM is implementing a full review of community nursing services within the next three months.
- In 2014, we spoke with a number of staff, and asked them if they felt competent and supported to meet the needs of the women they cared for. All told us that they did, and were all able to identify their supervisor of midwives. The senior midwife told us that the supervisor of midwifes ratio to midwives was one in 15, which, again, was within national guidelines.
- A new head of midwifery (HOM) was appointed across the trust in August 2014. Staff were positive regarding the current leadership, and the strong focus on governance and risk management since this appointment. They said that the HOM was proactive in managing midwifery staffing, such as the use of bank staff to cover shortfalls, and a plan to introduce temporary contracts for bank midwives. There was also a contingency plan formulated to include unit closure, if staff were not available to safely meet the demands of the service, either number or acuity.
- Staff also told us that they rotated to all areas within the maternity department, and felt this enhanced the upkeep of their skills and experiences.
- We saw an escalation policy, which detailed the process to follow should there be an increased demand. In busier periods, we saw that community midwives were asked to work in the labour ward.
- In 2014, we were told that in some areas, the community midwife ratio to women was between 130 and 160 women to one midwife. This was over the national guideline of one to 100 women. However, none of the community midwives we spoke with voiced any concern regarding their caseload.
- During our inspection in 2015, workforce planning was being undertaken, as currently there are 66.2 WTE community midwives across the trust, which is 1:100.8, which is in line with national guidance, so geographical allocation needs to be reviewed to reduce some caseloads. One health care support worker was appointed to the community team recently to provide additional support.
- We observed a handover between shifts, and saw that it was robust and comprehensive. None of the doctors or

midwives we spoke with voiced any concerns with the quality and detail of the handovers. All told us that they felt handovers were safe, and equipped staff to meet the needs of the women using the service.

Medical staffing

- There was good consultant presence between the hours of 9am and 9pm. The head of service explained to us there were 40 hours of consultant cover each week. This was compliant with the Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth recommendations.
- After 9pm, there was an on-call consultant and the maternity unit was staffed by a registrar and a senior doctor in training. The head of service went on to explain that a full and detailed ward round was conducted at 5pm to ensure adequate medical cover was maintained during the evening and night.
- We saw that locum doctors were used to ensure safe medical cover. The head of service explained that there was a continual effort to recruit doctors. None of the staff we spoke with indicated to us that they were concerned about the medical cover in maternity.
- At the last inspection in May 2014, a high level of locums was reported. We spoke with doctors and midwives, and no concerns were raised, and it was reported that usage of locums currently was low.
- We spoke with a number of women who used the service. They all told us they felt safe. One woman told us: "It is absolutely fantastic here. They [the staff] are reassuring and explain everything fully."

Major incident awareness and training

- We saw a maternity services escalation policy that was current and up to date. The policy detailed what to do in the event of a situation which could affect the safe care of women and their babies. The community midwives we spoke with also explained how they would work in the high priority areas, such as labour ward.

Are maternity and family planning services effective?

Good

There was a specialist midwife with responsibility to ensure all clinical effectiveness was embedded in practice and all policy and standards were evidence and research-based. The provider had robust systems in place for the ratification of new policies and guidance.

All relevant NICE guidance was reviewed in the maternity guidelines group and at the trust's clinical excellence steering group.

From the data relating to: the number of births, delivery methods, profile of births, analysis of maternal readmissions, emergency caesarean sections and neonatal readmissions, we saw that the trust's outcomes were within expected limits.

There was a specialist midwife with responsibility to ensure all clinical effectiveness was embedded in practice and all policy and standards were evidence and research-based. The provider had robust systems in place for the ratification of new policies and guidance.

We did not re-inspect this aspect of the service in February 2015.

Evidence-based care and treatment

- We saw policies, protocols and guidance were based on, and referenced, nationally recognised guidelines and standards.
- We saw there was a specialist midwife with responsibility to ensure all clinical effectiveness was embedded in practice and all policy and standards were evidence and research-based. The provider had robust systems in place for the ratification of new policies and guidance.
- We saw regular review and updating of policies and guidance. We spoke with staff and asked them if they were engaged in the development of policies and how new guidance was communicated to them. All the staff we spoke with told us they were notified when new policies or guidance was introduced.

Maternity and family planning

- We saw the that the trust's intranet contained all policies and staff were able to access the documents. All the documents on the intranet contained a clear review date and version control. This demonstrated that all policies, protocols and guidance were current.
- The old intranet was still accessible to staff and contained extremely outdated national guidance. While this was not the current intranet used by the majority of staff, staff were still able to view documents that were up to 12 years out of date. We raised our concerns with the clinical risk midwife, who showed us evidence of emails sent requesting the old intranet site be removed. This demonstrated the service had identified this as a risk, however, the trust had not acted upon the request.
- All relevant NICE guidance was reviewed in the maternity guidelines group and at the trust's clinical excellence steering group. The clinical risk midwife explained that, when new NICE or national guidance was published, the maternity guidelines group discussed implementation or demonstrated the rationale as to why the guidance was not implemented.
- We saw a variety of audits were conducted within the maternity service. These included such areas as record-keeping, cardiotocography interpretation, perineal tears, haemorrhage rates and difficult births. We also saw that an audit of 20 notes was carried out on a monthly basis action was taken in response to issues highlighted..
- Changes to practice were evident following audit findings. An example of this was the development of a pocket guide to cardiotocography (CTG) interpretation. This meant that audits were conducted, findings analysed and new practices embedded to improve outcomes for the women using the service.

Patient outcomes

- We saw a monthly quality report was produced and reported through the division and on to the trust board. We also saw the report was displayed in clinical areas. This meant the trust was able to action performance concerns and staff were able to understand what they were doing well and where improvements were required. We also saw a maternity dashboard, which measured performance against key performance indicators. All quality performance measures were discussed at the clinical governance meeting.
- From the data relating to the number of births, delivery methods, profile of births and analysis of maternal readmissions, emergency caesarean sections and neonatal readmissions, we saw that the trust's outcomes were within expected limits.

Competent staff

- Women told us they were cared for by suitable qualified and competent staff.
- The training data shared with us was of poor quality. We spoke with a senior midwife who explained to us that ward managers have a training folder for all staff in the clinical areas. Training attendance is manually checked at ward-level. This meant that we were unable to determine the exact number of staff who had accessed the training.
- The head of service explained that doctors were able to access clinical and educational mentors and had weekly one-to-one meetings with their mentors. They also had protected learning time on each Friday afternoon and followed an education programme. The head of service explained that doctors were able to access clinical and educational mentors and had weekly one-to-one meetings with their mentors.
- We reviewed the Women and Children's Division mandatory training figures. The data shared with us was of poor quality. This meant that we were unable to determine the exact number of staff who had accessed the training and had received an annual appraisal.

Multidisciplinary working

- We saw a robust governance committee structure, which included multidisciplinary working. The governance meetings reported into the governance committee. The governance committee was accountable to the trust board and had responsibility for risk management and governance. The head of service explained to us that the specialty governance meetings were open to all and attended by midwives, obstetricians, human resources staff, anaesthetists, paediatricians and paediatric nurses.
- We also saw perinatal mortality meetings were held weekly. These meetings were held to discuss complex cases or areas of concerns. These meetings were also multidisciplinary and involved staff with particular expertise.

Maternity and family planning

Seven-day services

- There was good consultant presence between the hours of 9am and 9pm. The head of service explained to us there was 40 hours of consultant cover each week. This is compliant with the Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth recommendations. After 9pm, there was an on-call consultant and the maternity unit was staffed by a registrar and a senior doctor in training. The head of service went on to explain that a full and detailed ward round was conducted at 5pm to ensure adequate medical cover was maintained during the evening and night.

Are maternity and family planning services caring?

Good

All the women we spoke with told us they were happy with their care and were able to comment about their experiences. Women's comments were included in the monthly quality report which was accessible to staff and reported through the clinical governance committee structure.

All women were seen about a month before they were due to give birth and a joint discussion was held to discuss women's hopes, wishes and plans for the birth and postnatal period. Women also had the contact details of their community midwife and the hospital, should support or guidance be required during their pregnancy, birth and postnatal period.

We did not re-inspect this aspect of the service in February 2015.

Compassionate care

- All the women we spoke with told us they were happy with their care. One woman told us: "I was shown around when I came in for treatment, I was thoroughly monitored. They were very good. My care was spot on." The women we spoke with told us that they had developed trusting relationships with the staff and that their individual needs and wishes were known and acknowledged. Partners were encouraged to visit and visiting times were waived for mothers in labour. During our visit, we also saw good staff interaction, which was polite and respectful.
- We saw evidence that the NHS Friends and Family Test was carried out and the results displayed in the clinical areas. We saw women and their families were able to comment about their experiences. The NHS Friends and Family test and women's comments were documented in the monthly quality report, which was accessible to staff and reported through the clinical governance committee structure. We saw that the NHS Friends and Family Test results were generally positive, however the response rate was very poor. We saw a response rate of between six and 17%.
- The CQC maternity survey results for 2013 showed that performance against the national average was better than other trusts for the question: 'At the start of labour did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?' In all other areas, the trust performed the same as other trusts.

Patient understanding and involvement

- The women we spoke with told us they felt involved in their care. Women and their partners told us they had taken part in making decisions and felt supported in their care. We saw that antenatal patients had their maternity notes to hand when in the hospital.
- We spoke with a number of community midwives, who explained to us all women were seen about a month before they were due to give birth and a joint discussion was held to discuss women's hopes, wishes and plans for the birth and postnatal period.
- Women were all given the contact details of their community midwife and the hospital, should support or guidance be required during their pregnancy, birth and postnatal period.

Are maternity and family planning services responsive?

Good

Improvements have been made to review and develop maternity services at Pilgrim Hospital, such as the introduction of a new unit to house maternity services, which is due to open in October 2015, and the provision of a birthing pool to provide women with more choice at time of delivery.

Maternity and family planning

We saw improvements in the maternity dashboard, which represented how national indicators were measured to show the responsiveness of the unit; however, it was not clear how patients were informed of these indicators.

Funding for a substance misuse specialist midwife has been approved, and there is further consideration for developing the specialist midwife roles across the trust, which is noted as work in progress.

Service planning and delivery to meet the needs of local people

- The staff we spoke with had a good understanding of the population who used the service and were all able to explain with confidence the requirements of the people who were inpatients.
- At busy times, staff were redeployed to the delivery suite. We discussed this with a senior member of the midwifery team. They explained that when there was a peak in activity, clinical care was prioritised and staff were moved to ensure the safest care possible was delivered.
- There was an escalation policy and the staff we spoke with understood the process. We spoke with a number of community midwives, who were very clear where they would be deployed to and how many hours they were able to work to ensure they remained in the limits of safe working.
- It had been recognised that due to the closure of the local birthing unit in February 2014, a woman's choice of where to have her baby was limited. The HOM reported that the maternity vision and strategy was being developed within the trust clinical strategy implementation group (CSIG), and linked with the wider health community involving commissioners, providers and NHS England, to look at future options for the maternity services across the trust, to ensure sustainability and improve choice options for women, such as looking at having a co-located unit.
- One of the important major projects at Pilgrim Hospital, is the introduction of a new unit to house maternity services, which is due to open in October 2015.

Access and flow

- None of the staff we spoke with felt there were any concerns with the flow of women through the maternity services. The staff told us that the maternity unit had not had to close due to over-capacity in 2012 and 2013.
- In 2014 we asked to see the maternity quality dashboard. The dashboard is a document which captures specific key performance data, and was presented through the governance structure to the board. This meant that the board were able to see at a glance how maternity were performing against the indicators, such as rates of caesarean section, haemorrhage, perineal tears and difficult birth outcomes.
- In 2015 we saw improvements in the maternity dashboard, which represented how national indicators were measured, such as clinical activity, clinical outcomes, and workforce levels, in line with national acuity tools. There were reporting mechanisms for risk incidents/complaints and patient satisfaction surveys, and staff were aware of how to access this information. However, it was not clear how patients were provided with this information to show how responsive the trust was, as it was not clearly displayed.

Meeting people's individual needs

- Staff had access to interpreters and could access the language line service. The majority of staff told us that they used this service when required and found it useful. The staff were able to explain with confidence the most common languages used in the area. When asked how useful these services were, the majority of staff told us that they were very useful.
- We saw a variety of information leaflets in various departments. We asked how staff accessed leaflets in different languages. We were told that leaflets were easily accessible in different languages. One community midwife explained that information was sent out to women in specific languages, prior to their first antenatal appointment. Previously, all the signage we saw was in English, which did not cater for people whose first language was not English. On this inspection there were large user-friendly pictorial signs outside the wards, with guidance in several different languages to assist people.
- Currently, Pilgrim Hospital maternity women are triaged and managed by the appropriate lead professional, such as a midwife for low risk, and consultant for high risk. Since the last inspection in March 2014, to improve choice the trust have put in place on the labour ward a fully functional birthing pool, which is available 24/7 for

women with low risk pregnancies. The midwives are attending normality training, to encourage women to use this facility for pain relief in the first stage of labour, and for delivery where they choose a water birth.

- We asked what specialist midwives or services were available for people with complex or challenging needs. We were told that satellite clinics were held in areas where women would find it difficult to travel to hospital locations for their care and treatment. The head of service explained to us that midwives, consultant obstetricians and an ultrasound service were available at these clinics.
- There were no specialist midwives for bereavement, substance misuse or safeguarding in May 2014. The HOM is currently looking at specialist midwife lead roles across the trust to develop maternity services. We saw active recruitment for a safeguarding lead, and a recent proposal as part of CQUIN for commissioners to fund a band 7 substance misuse lead to support vulnerable women. Staff we spoke with were aware of further lead roles in bereavement, teenage pregnancy, and diabetes and obesity being considered, but this was acknowledged as work in progress.
- Antenatal clinics had been expanded to accommodate increased demand. For example, we noted that a clinic had been developed for women with an increased body mass index (BMI).
- Due to the environmental constraints of the ward, support for partners staying overnight is limited. However, eight recliner chairs had recently been purchased for partners to sleep in. Blankets were available, but partners were asked to provide any other bedding they may require.

Learning from complaints and concerns

- The provider had a robust complaints process and we saw evidence of learning from these. We saw complaints and learning were discussed at the clinical governance meeting and reported through to the business unit. We also saw that comments and suggestions were listened to and acted upon. One ward manager explained that partners of women using the service had complained facilities were poor when staying overnight at the hospital. Several reclining chairs had been purchased and were due for delivery very shortly.

Are maternity and family planning services well-led?

Good

The head of midwifery post had been vacant for three months. We found no evidence to show us that a formalised system had been put into place to ensure the head of midwifery post was temporarily covered until a replacement head of midwifery employed.

There had been an identified risk regarding the presence of asbestos and a recurring leak. We saw that immediate action was taken when the leak occurred.

We did not re-inspect this aspect of the service in February 2015.

Vision and strategy for this service

- During the staff interviews and focus groups, the vision and values of the trust were not clearly identified by staff. Some staff identified the element of being financially sustainable as a key aim of the trust.

Governance, risk management and quality measurement

- We saw a robust governance framework and reporting structure. Incidents, serious untoward incidents, complaints and audits were analysed and reported through the committee structure to the board. We saw that quality data was also displayed in the clinical areas and reported to the clinical governance meetings, which were open to all staff to attend. This meant staff had opportunities to understand trends, learning and changes to practice.
- Risks to the delivery of high quality care were identified, analysed and controls put into place. Key risks and actions were reported through the governance structure and reported to the board. However, there had been an identified risk regarding the presence of asbestos and a recurring leak. We saw that immediate action was taken when the leak occurred.

Leadership of service

- The medical staff we spoke with told us they felt well supported by senior colleagues. One doctor told us: “I have good supervision and experience. I also have access to educational resources.” During our inspection,

we observed a multidisciplinary handover between shifts. The care was handed over consultant to consultant. We observed the handover to be open and all levels of staff were able to contribute.

- The midwifery and support staff we spoke with told us they had good support from ward managers and modern matrons. Midwives also had 24 hour access to supervisors of midwives.
- There had not been a head of midwifery in post for three months and, as such, we were told by senior midwives this had had an impact on their availability to lead, manage and support staff. One modern matron explained to us that they felt overstretched at times and that they were not always as visible as they would have liked to be. We found no evidence to show us that a formalised system had been put into place to ensure the head of midwifery post was temporarily covered until a replacement head of midwifery could be employed. However, staff were able to confirm the head of midwifery post had been filled and had met the new appointee.
- We were able to confirm that the executive team were visible and staff explained that members of the board visited the location at least once a week. During our inspection, the chief executive was on-site.

Culture within the service

- The majority of staff told us they felt supported and had access to more senior staff, when required. Staff told us they were able to raise problems and concerns without fear of discrimination and managers and modern matrons were accessible. All staff had access to a supervisor of midwives.

Public and staff engagement

- We saw evidence that women, families and staff were engaged and their views sought. Women and their families comments were displayed in the clinical areas and were included in the quality report. They were also reported through the governance reporting structure to the board. The majority of comments we saw were positive about the care and experience received.

Services for children and young people

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

Information about the service

A paediatric service for children ranging from zero to 16 years of age is provided at the hospital, including:

- An emergency service with links to inpatient beds.
- An elective and day case service, including assessment on the paediatric ward.
- An outpatient service in the general outpatients department.
- A special care unit with 12 cots for babies born at Pilgrim Hospital under level 2 criteria set by the Trent Perinatal Network.

The service is available seven days a week and offers 24 hour cover at Pilgrim Hospital, Boston. The consultants have a range of specialist interests, such as general paediatricians with interests in epilepsy and neonatology. There are six consultants, eight middle grade doctors and eight doctors in training. The paediatric consultants cover both the labour ward and the paediatric and neonatal areas.

In 2014we spoke with eight family members and four children who used the service. We also spoke with nine nurses, two support workers, two administration workers, and six doctors. In 2015, we spoke with 12 nurses, one nursery nurse and four doctors, two sets of parents, and we reviewed two sets of patient records.

Summary of findings

There was no dedicated high dependency unit (HDU) provision. The staff we spoke with told us this meant that children with complex requirements were often nursed on the general paediatric ward. In 2015, the service had implemented an acuity tool to monitor the dependency of patients within the service. This information was being used to ascertain the number of staff required on a shift, and was also being shared with the clinical commissioning group (CCG).

In 2014 we found that there was no access to the child and adolescent mental health service for those children and young people who required specialist mental health support. In 2015 we found that improvements had been made to ensure child and adolescent mental health services (CAMHS) could be accessed 24 hours a day and seven days a week. The service had also secured four self-harm nurses, two of which supported Lincoln County Hospital. These nurses could respond within two hours of being contacted.

In 2014 we found that on a significant number of shifts, the staffing levels fell below the recommended levels. In 2015 we found that the service had taken steps to mitigate the risks of unsafe staffing levels by closing beds, but was still not meeting the staffing recommendations issued by the RCN.

Services for children and young people

In 2014 we found that beds and cots were stored in the corridors, which made the environment cluttered and a risk to the patients using the service. In 2015 we saw that a room had been dedicated to the storage of such equipment.

Are services for children and young people safe?

Requires improvement

Services for children require improvement as, due to the lack of high dependency services, children with complex needs were often nursed on the general paediatric ward.

In 2014 we saw there was limited access to the child and adolescent mental health service for those children and young people who required specialist mental health support. In 2015 we found that improvements had been made to ensure child and adolescent mental health services (CAMHS) could be accessed 24 hours a day and seven days a week. The service had also secured four self-harm nurses, two of which supported Lincoln County Hospital. These nurses could respond within two hours of being contacted.

On a significant number of shifts the staffing levels fell below the recommended levels.

There was no continuity of consultant cover for the neonatal unit.

In 2014 we saw that beds and cots were stored in the corridors which made the environment cluttered and a risk to the patients using the service. When we inspected in 2015 we saw that improvements had been made, and a dedicated room was allocated to the storage of equipment such as beds and cots.

There was poor trust-wide data collection of attendance to training.

Incidents

- There was an effective mechanism to capture incidents, near misses and Never Events. Staff told us they knew how to report, both electronically and to their manager. We saw a robust governance framework which positively encouraged staff to report incidents and information on how to complain was visible to the people using the service.
- We asked staff to explain how learning from incidents and complaints was cascaded to all staff. Their responses indicated to us that learning and trends from

incidents and complaints was disseminated to staff. We saw evidence that these were discussed in the clinical governance meetings, which were open to all staff to attend.

- One senior member of staff described a recent medication error to us. They explained the incident was reported, analysed and actioned. The incident was discussed at the clinical governance meeting and policies and procedures were amended to reflect the learning from the incident.
- We also saw that the paediatric service was involved in the monthly perinatal mortality meeting. The head of service explained to us that these meetings were used to present complex cases and also as a forum for staff to discuss good practice, learn and improve on practice that was less good.

Safety thermometer

- We spoke with the modern matron who explained to us they had reviewed Safety Thermometers specific to paediatric care across the NHS. A decision had been taken to adapt the Sheffield model. We were told all work had been completed and approved and would shortly be piloted in the service.

Cleanliness, infection control and hygiene

- The data we reviewed suggested that infection control rates were within a statistically acceptable range. During our inspection in 2014, we saw that the environment was clean. However, the majority of staff we spoke with explained to us that they did not have access to a routine domestic service after 12 noon every day. The staff told us that this meant they relied on the rapid response team, should they require an area to be cleaned. In 2015 the matron told us that they had two housekeepers between the hours of 8am and 3pm, Monday to Friday, and 8am to 12 noon, Saturday and Sunday. We saw that cleanliness standards were audited on the neonatal unit, and were consistently between 97-99%.
- We saw that a robust infection prevention and control audit programme was undertaken. This included weekly audits, which monitored hand hygiene, the environment, drug prescribing and the use of urinary catheters and cannulas. We also saw that an extensive annual audit was carried out between January and March 2014. Ad hoc "glow and tell" checks were also carried out, at least once a year on each area. This test shows how well staff wash their hands by using an ultra violet scanner.
- If a patient was found to have either C. difficile or MRSA, they could be isolated in a side room.
- We spoke with the infection control lead, who told us the paediatric service had a good infection prevention and control link, who was proactive and very engaged with the trust policies and practices

Environment and equipment

- In 2014 we found the environment to be clean. However, there was little available storage for equipment in some areas. Staff told us, and we observed, that storage was a major issue and risk. Beds and cots were stored in the corridors, which made the environment cluttered, and a risk to the patients using the service. We saw that the risk had been identified and was documented on the risk register. However, at the time of our inspection it remained a concerning risk. When we returned in 2015, we saw that a designated room had been provided for the storage of equipment, such as beds and cots, when they were not in use.
- In 2014 the beds we saw were old and in need of attention, as they appeared quite battered. Staff told us that to be able to care for their patients well, they required electronic beds. Staff told us that there was a trust-wide plan to replace old and outdated beds. However, we were unable to determine when this would happen. When we returned in 2015, we saw that some of the beds had been replaced with electronic profiling beds. The trust had invested in 10 new beds for the ward through the trust scheme.
- In 2014 the staff we spoke with told us there was a rolling programme to replace the paediatric intravenous pumps. This had not been initiated, and no training programme established. When we returned in 2015, staff told us that they had been trialling pumps, and training had been provided for the pumps they were using.

Medicines

- We saw all medication was checked by two nurses.
- We noted the last serious reported incident was for medication that was unaccounted for in 2013. Staff explained new checks had been put in place to mitigate the recurrence of the incident.

- Staff explained to us that individual medication errors were thoroughly investigated. Staff that made more than one mistake were given further education or training.

Consent

- We saw a standardised consent form with space for the parent, carer, child or adolescent to sign or co-sign.
- We saw that staff were able to access an e-learning module in awareness of mental health issues linked to consent.
- We saw that staff followed best practice where there may be an issue about the ability to consent of a young person.

Safeguarding

- We asked a number of staff to describe the training they had received in relation to safeguarding the vulnerable adult and child. All staff told us they had received the appropriate training.
- There was also a designated doctor for safeguarding available to staff should they require support and guidance. They explained to us that they had concerns regarding access to out-of-hours safeguarding advice and support.
- In 2014 we asked for the training records of attendance to the training; however, we did not receive data to assure us that safeguarding training had been undertaken. A senior nurse and doctor explained that all staff had attended, but there was no formal process for collecting the data. We were assured that this was being addressed. We saw trust-wide databases, which were beginning to be populated with training data. In 2015 we saw a database which detailed the staff who had attended safeguarding level 3 training; 82% of registered nurses had completed this training at the time of our inspection.

Mandatory training

- In 2014 we reviewed the women and children's division mandatory training figures. The data shared with us was of poor quality. This meant that we were unable to determine the exact number of staff who had accessed the training. We spoke with a senior nurse and doctor, who assured us that training was undertaken, but the recording of attendance was poor. When we returned in 2015, we looked at mandatory training, and could see that uptake of mandatory training still required improvement. We found that on average, the mandatory training figures were at 67% for staff working on the paediatric ward. A senior person told us that mandatory training had been cancelled throughout November and December because of Winter pressures. However, there were plans in place to ensure that the service met its target of 95% for mandatory training by March 2015.

Management of deteriorating patients

- In 2014 we saw that there was no dedicated high dependency unit (HDU) provision. There was a transfer protocol in place, but not all children were transferred in a timely manner. This meant that children with complex requirements were often nursed on the general paediatric ward by staff not experienced in this area of care. When we visited in 2015, we saw that a single room had been equipped to deal with children who required high dependency care. The service was not commissioned for high dependency care, but retrieval teams from neighbouring trusts would not collect patients until they were intubated.
- An audit was carried out and reported to the board in April 2014. The audit showed that during one month, the ward had at least one patient requiring HDU care. In 2015, we saw that between 1 October 2014 and 2 February 2015 there had been a total of 42 days of HDU activity on Ward 4A. This meant that the care and welfare of children was compromised at times, because the paediatric service was unable to provide the level of care required.
- The use of paediatric early warning tools had been introduced in 2014. This, however, did not mitigate the risk to children requiring HDU care.
- In the special care baby unit (SCBU) they followed protocols from the Trent Perinatal Network, and were able to access cots for those neonates requiring more intensive care through a central contact.
- In 2014 staff also told us they were unable to access child and adolescent mental health services for those children and young people who required specialist mental health support. As a result, the staff told us that they were admitted to the ward, and often required one-to-one nursing to ensure that they and other patients were safe. In 2014 a Serious Incident had been reported through the incident reporting system, which resulted in the closure of the ward for a substantial amount of time, because a young person had been admitted with severe mental health concerns. The lack

of the specialist mental health service had been raised with the board and with external commissioning services. In 2015, we found that improvements had been made to ensure child and adolescent mental health services (CAMH) could be accessed 24 hours a day and seven days a week. The service had also secured four self-harm nurses, two of which supported the Pilgrim Hospital. These nurses could respond within two hours of being contacted. The matron for the children and young people's services told us that they worked proactively with the CAMH(S) service and the self-harm nurses.

Nursing staffing

- We spoke with staff and asked them if they had enough staff to meet the needs of their patients. All told us they felt they did not have the required amount of staff. We saw that the staffing levels on the paediatric unit were at a one to six children ratio, which was below the national recommendation. This meant that the bed occupancy did not reflect the potential complexity of the workload.
- The neonatal unit was adequately staffed and in line with the British Association of Perinatal Medicine standards for the necessary nursing skills.
- In 2014 a benchmarking exercise against the Royal College of Nursing (RCN) guidance for registered nurse ratio to patients had been undertaken. The findings showed us that on a significant number of shifts the staffing levels fell below the recommended levels. This was reported to the board in April 2014, but at the time of our inspection it had not been addressed. When we returned in 2015, we found that the staffing levels were still below the levels recommended by the RCN. Steps had been taken to mitigate risks, and beds had been closed from 24 to 19 beds. When all beds were occupied, this meant that staffing levels were at least one to five. Nursing staff told us they felt that staffing levels were better since the closure of the beds. However, staff expressed that they still felt the service was overstretched, especially when patients have high dependency needs for care.
- In 2015, ward staff told us that there were occasions when beds were re-opened for children requiring elective surgery, and this put additional pressure on staff.

Medical staffing

- In 2014 we spoke with staff, who told us that there was full complement of medical staff. However, the consultants we spoke with told us that they felt they needed a further consultant to be appointed. This was because they were unable to give adequate cover to the neonatal unit.
- The modern matron for the neonatal unit told us there was not enough paediatric consultant cover to provide cover to the neonatal unit. This meant that there was no continuity of consultant cover for the unit. In 2015, we found that no further action had been taken to recruit the additional consultants required to deliver a safe service. The modern matron for the neonatal unit told us that there was not enough paediatric consultant cover to provide cover to the neonatal unit. This meant that there was no continuity of consultant cover for the unit.

Are services for children and young people effective?

Good

We saw that all policy and standards were evidence and research-based. The provider had robust systems in place for the ratification of new policies and guidance.

We saw an example of a joint clinic for children with diabetes. This clinic was attended by both a paediatrician and an adult service specialist. This demonstrated continuity of care into the adult service.

We found little evidence to suggest local clinical effectiveness audits were carried out. Work was in progress to implement systems and processes to audit, monitor and benchmark clinical effectiveness.

We did not re-inspect this aspect of the service in February 2015.

Evidence-based care and treatment

- We saw that all policy and standards were evidence and research-based. The provider had robust systems in place for the ratification of new policies and guidance.
- All relevant NICE guidance was reviewed in the clinical records group and at the trust's clinical excellence steering group.

- In the neonatal unit, we saw that British Association of Perinatal Medicine guidelines were used and that monitoring of the service was undertaken by the Trent Perinatal Network.
- We found little evidence to suggest that local clinical effectiveness audits were carried out. Staff were able to demonstrate that work was in progress to implement systems and processes to audit, monitor and benchmark clinical effectiveness. This meant that, at the time of our inspection, clinical effectiveness and adherence to policies was not measured.

Pain relief

- There was a trust-wide paediatric pain policy, which had been in use for some years. The document had recently been revised and was awaiting final ratification through the clinical records committee.

Nutrition and hydration

- In the neonatal unit, staff told us that they had acquired the UNICEF Baby Friendly status in supporting parents with breastfeeding.
- Guidelines for starvation and deprivation of fluids were within national paediatric guidelines. All children were nutritionally assessed using a recognised national tool and could be referred to a dietician within the trust with a paediatric interest.
- There were fluid charts maintained within the care plans.

Patient outcomes

- From the trust's quality account we were able to see that the paediatric service participated in a variety of national clinical audits. We saw that, in 2013, the service participated in the paediatric asthma audit, the national neonatal audit programme, the paediatric diabetes audit and the monitoring of readmission rates.

Competent staff

- A consultant explained to us that doctors were able to access clinical and educational training and had external appraisals and validation of their training both during and at the end of their placement.
- The consultant responsible for the training of doctors, explained to us that the trust was aware of the poor data collection around attendance at training and were in the process of developing a system for the collection of the data. We were able to see that this had commenced.
- We spoke with a senior nurse, who explained that training records were kept in each clinical area and the ward manager monitored attendance at training. Again, we found that data collection was poor and we were unable to determine what percentage of staff had attended what training.
- The staff we spoke with told us that, because of the limited nurse staffing levels, they were often unable to attend training.

Multidisciplinary working

- We saw a robust governance committee structure in place, which included multidisciplinary working. The governance meetings reported into the governance committee. The governance committee was accountable to the trust board and had responsibility for risk management and governance. The head of service explained to us that the specialty governance meetings were open to all and attended by midwives, obstetricians, human resources staff, anaesthetists, paediatricians and paediatric nurses.
- We also saw that perinatal mortality meetings were held weekly. These meetings were held to discuss complex cases or areas of concerns. These meetings were also multidisciplinary and involved staff with particular expertise.
- We saw an example of a joint clinic for children with diabetes. This clinic was attended by both a paediatrician and an adult service specialist. This demonstrated continuity of care into the adult service.
- We also saw that the lack of child and adolescent mental health services provided to the trust had been discussed with external stakeholders.

Seven-Day services

Consultant presence potentially could be an issue at busier times because consultants, middle grade doctors and doctors in training covered the labour ward, the paediatric ward and the neonatal unit. None of the staff we spoke with raised this as a concern with us.

Services for children and young people

Are services for children and young people caring?

Good

The families we spoke with could not praise the quality of care highly enough and the staff involved them in decision-making, care and treatment planning.

Patients and family members were able to comment and raise concerns about their care.

We did not re-inspect this aspect of the service in February 2015.

Compassionate care

- The families we spoke with could not praise the quality of care highly enough. One parent told us: "The nurses are absolutely fantastic. They reassured me and explained everything fully."
- We observed the interaction between staff and families and found it to be excellent.

Patient understanding and involvement

- The parents we spoke with on the neonatal unit told us they were involved in decisions about their babies' treatment. They told us that they were encouraged to join the doctors' ward round for their baby.
- The paediatric service did not use the national NHS Friends and Family Test tool. However, we saw exit cards for all children and families to complete prior to discharge.
- A senior member of staff explained that the NHS Friends and Family Test is intended to be rolled out nationally for paediatric services by April 2015 and will be piloted by Lincolnshire prior to the rollout.
- Compassionate care and emotional support was assessed with the exit cards at present. There was no audit tool.

Emotional support

- One mother told us that she had been supported by the neonatal unit while on the transitional ward and that "it was good to be able to stay with her baby and get so much help".

Are services for children and young people responsive?

Good

In 2014, medical and nursing staff had concerns with nursing staffing levels, increased acuity of patients, management plans for young people with mental health concerns, lack of dedicated assessment facilities and adolescent facilities. In 2015, we saw a business unit action plan had been developed, and reported to the board in April 2014. The plan highlighted the areas of concern, such as nursing staffing levels, increased acuity of patients, management plans for young people with mental health concerns, lack of dedicated assessment facilities, and adolescent facilities. In 2015, we were told that the business unit action plan had been fed into the Lincolnshire health and care (LHAC) transformation. This had led to the development of two possible models for the delivery of women's and children's services. The trust had done all it could to mitigate the risks it had control of.

In 2014, bed occupancy was not reviewed by dependency. This meant that the bed occupancy tool used did not reflect the potential complexity of the workload. In 2015, we saw that the service was using an acuity tool to monitor the dependency of patients requiring care.

In 2014 there were no criteria or pathways for children who were transitioning to adult services. In 2015 there was a pathway for adolescents with diabetes, but there were no criteria or pathways for adolescents with other long-term conditions, such as cerebral palsy or cystic fibrosis.

Service planning and delivery to meet the needs of local people

- The staff we spoke with had a good understanding of the population using the service and were all able to explain with confidence the requirements of the people who were inpatients. However, the majority of staff we spoke with felt the service on the paediatric ward was overstretched and told us they felt children were not always cared for in an appropriate setting and with sufficient nursing staff.
- In 2014 we saw a business unit action plan had been developed and reported to the board in April 2014. The plan highlighted the areas of concern, such as nursing staffing levels, increased acuity of patients, management plans for young people with mental health concerns, lack of dedicated assessment facilities,

and adolescent facilities. This had been reported to the board in April 2014, but had not been addressed. In 2015, we were told that the business unit action plan had been fed into the Lincolnshire health and care (LHAC) transformation. This had led to the development of two possible models for the delivery of women's and children's services.

- Staff on the neonatal unit told us about the escalation policy they used and that they felt confident in using this.
- There was a trust paediatric escalation policy specific to paediatric referrals and bed closure. This policy worked through the modern matron and agreement was sought from the operational manager and executive lead for the service.
- Staff were able to share an example where the escalation policy had been used

Access and flow

- None of the staff we spoke with indicated that they had concerns with the access to the service. However, the paediatric ward went on to tell us that the service took direct referrals from general practitioners, nurse practitioners, A&E, outpatients and directly from family members, where a child was in receipt of care at another tertiary centre.
- In 2014 we saw that bed occupancy was 60 to 80%. However, staff felt strongly that the beds occupancy was not reviewed by dependency. This meant that one-to-one care was not taken into account. When we returned in 2015, we found that the service had been using an acuity tool to monitor the dependency of patients. This information was also going to be used by the clinical commissioning group to prioritise the need for high dependency facilities within the service.

Meeting people's individual needs

- Staff had access to interpreters and could access the language line service. The majority of staff told us they used this service, when required, and found it useful. The staff were able to explain with confidence the most common languages used in the area. When asked how useful these services were, the majority of staff told us they were very useful. We also saw a variety of information leaflets in departments. We asked how staff accessed leaflets in different languages. We were told that leaflets were easily accessible in different languages.
- We asked what specialist services were available for children and young people with complex or challenging needs. The only example staff were able to share with us was that the unit offered a phlebotomy service for patients to access. This meant that local patients did not have to travel to other locations to have blood samples taken.
- The modern matron spoke with us about a specialist transitional and home care team. They explained that four beds were attached to the neonatal unit. This unit enabled mothers and babies to remain together and empowered the mothers to care for their babies. The team also enabled safe, earlier discharge of babies with additional home support. The team also provided an outreach service to the postnatal wards. This meant that midwifery staff and mothers were given support to care for babies who would have previously been nursed in the neonatal unit. The modern matron explained that readmission rates were measured and monitored. However, they were unable to supply the figures for us to view.
- In 2014, there were no criteria or pathways for children who were transitioning to adult services. Staff explained that each case was dealt with on an individual basis, with the transferring consultant engaging with the receiving consultant. In 2015, we spoke with a consultant who told us there was no clear policy for adolescents who were transitioning to adult services. The service cared for children with long-term conditions up to the age of 16 years, and would continue to care for them until they had completed their GCSEs. Children who required the input of an oncologist were cared for by the children's team until they were 18. There was a clear pathway for those children with diabetes, but there was no pathway for children with other long-term conditions, such as cerebral palsy or cystic fibrosis.

Learning from complaints and concerns

- Staff told us that there was a good link with the Patient Advice and Liaison Service, which had been relaunched six months previously.
- The ward manager explained that the majority of complaints were dealt with at ward-level. We saw examples of complaints and the learning that had taken place following the concern being raised.

Services for children and young people

Are services for children and young people well-led?

Good

In 2014 staff in the neonatal unit told us that they rarely saw the nurse consultant, risk manager or the practice development nurses. This was because senior nurses were based at the Lincoln County Hospital and, as such, found it difficult to visit other locations. There was a schedule for senior nurses to visit other locations, but they struggled to meet these commitments. In 2015, staff told us that senior nurses were more visible within the service. All three were present at the time of our inspection.

In 2014 the majority of staff we spoke with were concerned about the future of the paediatric service at Boston. They explained to us that communication from the board, regarding the sustainability review, was poor. In 2015 we saw that communication had taken place via emails, the trust's intranet, and staff had been invited to attend public engagement meetings regarding the future of the service. The future of the service was being reviewed by the LHAC, and two models for the future of the service had been proposed. Staff were apprehensive that the transformed service would be based at the Lincoln County Hospital site, and were worried about what this might mean for them and their jobs. Some staff told us that they were still not aware of the full extent of the plans for the service.

Vision and strategy for this service

- In 2014 the neonatal staff we spoke with were not clearly able to identify the trust's vision and values. One staff member spoke of being mostly guided by the Trent Perinatal Network guidelines.
- The paediatric staff were not clear on the trust's vision and strategy. However, they were aware that there was a sustainability service review being undertaken, and that this would lead to the ultimate vision and strategy for the child health service.
- In 2014, the majority of staff we spoke with were concerned about the future of the paediatric service at Boston. They explained to us that communication from the board, regarding the sustainability review, was poor. When we returned in 2015, staff were more familiar with the trust's vision and values, but some staff expressed uncertainty about the future of the service. The future of the service was being reviewed by the LHAC, and two models for the future of the service had been proposed. Staff were apprehensive that the transformed service would be based at the Lincoln County Hospital site, and were worried about what this might mean for them and their jobs. Some staff told us that they were still not aware of the full extent of the plans for the service, but we saw that information had been shared with staff via email, the trust's intranet, newsletters, and staff had been invited to attend monthly public meetings.

Governance, risk management and quality measurement

- In 2014 we saw a robust governance framework and reporting structure. However, at the time of our inspection, there were no robust systems for collecting quality data. Staff told us that a quality dashboard was in development, and due to commence in July 2014. When we inspected in 2015 we found that the service had only just started to collect quality data. We could see this had taken place, but the data was not available at the time of our inspection.
- Risks to the delivery of high quality care were identified, analysed and controls put into place. Key risks and actions were reported through the governance structure and to the board.

Leadership of service

- In 2014 the medical staff we spoke with told us that they felt well supported by senior colleagues. However, we were told by a senior consultant that they felt the service was safe, but that senior doctors were expected to cover hospitals in the Boston and Grantham areas, as well as in the community. The service was bidding for a seventh consultant to improve the support for staff and services. In 2015, we spoke with medical staff, who told us that a business case for a further two WTE consultants had been rejected on the grounds of finance. It was felt that this was because of the uncertainty of the changes that were surrounding the service as it was undergoing a period of consultation to transformation.
- In 2014, the nursing and support staff we spoke with told us they had good support from ward managers, but very rarely saw the nurse consultant, risk manager or the practice development nurses. The modern matron explained to us that the senior nurses were based at the Lincoln County Hospital and, as such, they found it difficult to visit other locations. We were told there was a

schedule for senior nurses to visit other locations, but that they struggled to meet these commitments. In 2015, staff told us that these staff were more visible at the hospital, and that they attended the hospital at least once a week.

- The executive team were visible and staff explained that members of the board visited the location at least once a week. During our inspection, the chief executive was on-site.

Culture within the service

- Staff in the neonatal unit spoke positively about the service they provided for patients.
- Staff told us there was a good, open culture within the paediatric service. One member of staff told us: "Management have been very flexible with the way I work and I am able to have a good work life balance."
- Family members told us there was a supportive culture. One mother told us: "I am pleased with the culture of care. I work within the profession and I feel very strongly that the levels of care here are very high."

Public and staff engagement

- Families and the general public have raised funds for the service. The last bed and cot replacement programme was funded by families and the public.
- There is a close relationship with local schools. School children have visited with their art class to paint murals on the walls to improve the child-friendly environment. We saw that the walls had been painted with animals, fairy tales and nursery rhymes.

End of life care

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

Information about the service

We selected three wards to visit that, when required, provided end of life care services at Pilgrim Hospital. We went to ward 6a, a general medicine ward for older people and ward 6b, a care of older people ward. We also visited ward 7b, a general medicine ward. We spoke to ten staff. These included: medical staff, nurses, occupational therapists, care staff and domestic staff.

We spoke to 15 patients to find out their views of the service. We also spoke to three relatives.

Pilgrim Hospital had formed a partnership with a local hospice, which is located very near to the hospital site.

There were specialist end of life care doctors who provided support to people requiring care at the end of their life.

Summary of findings

The service was safe. There was a good culture of reporting and learning from incidents. Records were in place documenting patients' wishes regarding resuscitation that were appropriate. Some records did not always document the involvement of relatives in the decision-making process.

The service was effective, working to the Gold Standard Framework. Patients' pain relief was prescribed and administered in a timely manner. The trust had taken part in the National Care of the Dying Audit, the results of which were awaited at the time of our inspection.

The service was caring. Patients received care from staff that was attentive and sensitive to their needs. Patients and the families we spoke with were positive about the care they received. Patients' privacy and dignity was maintained.

The service was responsive to patients' individual needs. In 2014, staff told us that end of life care services were planned on the principle of person-centred care. This meant that patients' wishes were at the centre of decisions made about their care. However in 2014, only 17.5% of patients who died in the hospital were seen by the palliative care team. Staff reported high demand for support from the palliative care team, which they were not able to provide. We were told that the trust was

End of life care

going to address this through the recruitment of an additional palliative care nurse. In 2015, we found that the trust had implemented link nurses on each ward, who identified patients at the end of their life.

The service was well-led. We found that staff shared the visions and values of the trust. Namely, that the patients were at the centre of decisions made about how the service was run. The views of patients and staff were being proactively sought to drive up standards at the service.

Are end of life care services safe?

Good

Patient feedback was positive about the services at the hospital. Patients felt they were receiving safe and suitable care from staff on the wards that we visited.

There were systems in place to quality check and monitor the health and safety of patients receiving end of life care at the hospital.

The ward environments we visited were safe and suitable to meet patients' needs. The trust had recruited an additional nurse to join the team, to increase the number of patients who could benefit from the service.

Staff followed policies and procedures to ensure that they cared for patients safely. Staff were also provided with training to ensure that they provided safe and suitable care and treatment.

We did not re-inspect this aspect of the service in February 2015.

Incidents

- The number of serious incidents reported within the trust were as anticipated for a trust of this size. There had been no incidents that related directly to patients who received end of life care.
- All staff we spoke with told us that they were encouraged to report incidents and received direct feedback from the ward sisters or matron. Staff told us that themes from incidents were discussed at regular meetings and staff were able to give us examples of where practice had changed as a result of incident reporting. Information was also fed back to staff via email and placed on staff notice boards, where relevant.

Environment and equipment

- We saw that staff used suitable equipment to assist patients safely with their care and treatment. For example, staff used hoists and slings when they assisted patients with reduced mobility.
- The design of the wards enabled staff to monitor and care for patients safely. There were single rooms and if close observation was required, rooms were available next to the nurse stations.

End of life care

Medicines

- Anticipatory end of life care was appropriately prescribed. This was audited regularly by the palliative care team.
- Appropriate syringes were available, when required, to deliver subcutaneous medication.

Records

- Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms that we saw were signed by an appropriately senior member of staff. The trust audited their DNA CPR forms annually, to ensure that they were always completed properly. Recent audits had found that there was a low level of relative involvement in the decision-making process. Although this was not specifically related to people who did not have capacity, this could impact on how people were supported to make decisions around resuscitation if families were not involved in the formal decision-making process.
- Risk assessments were completed and reviewed regularly and care plans relating to patients' needs were in place. These set out how to provide patients with safe and effective care and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were systems in place to ensure that patients who did not have capacity to consent to care and treatment and these were followed appropriately by staff. Staff told us they had received training around consent.

Safeguarding

- Staff received training to understand what safeguarding was. Staff also knew about whistleblowing and how to report concerns if they had them.

Mandatory training

- Staff reported that they had received mandatory training in health and safety, safeguarding and infection control.
- Wards had designated training leads to provide on-the-job training for staff. For example, training was available in pain management, emergency resuscitation and caring with dignity.

Assessing and responding to patient risk

- Specialist support was available for staff from a trained specialist nursing team (the palliative care team) when required.
- There was a specialist palliative care nurse who worked across the hospital site. Staff told us that requests for the support of the specialist palliative care nurse could not always be met, due to demand. This had been recognised by the trust, who had recruited an additional nurse to join the palliative care team. This nurse was shortly due to join the team.

Nursing staffing

- Staff had a varied understanding of how staffing levels were calculated for their wards. Staff believed numbers were calculated based on a dependency tool, but had a mixed understanding of which tool was used.
- Staffing levels varied across the wards because staff were supporting other wards, where cover was necessary, on a regular basis. Staff told us that this had led to additional time pressure on these occasions, to meet patients' needs. Staff felt they were able to meet patients' needs at these times, but they were increasingly time-pressured to do so.
- Regular agency and bank staff were used where possible, to ensure continuity of care for patients.

Medical staffing

- Ward rounds were held daily and end of life care assessments were carried out at these meetings.
- On-call, out-of-hours consultant cover operated at weekends and nights.
- There was out-of-hours medical cover at weekends and nights. This included an end of life care consultant who had been recruited by the trust in the six months prior to our inspection.
- There was a locum consultant providing medical cover across older peoples' wards in the absence of an additional permanent consultant for these wards. The staff told us the locum consultant had worked at the trust for over five years.

Are end of life care services effective?

Good

At the time of our inspection, 17% of patients benefited directly from specialist end of life care support from the palliative care team. The team provided effective guidance and assistance to patients and their families. People could be referred to the service by other specialities within the hospital.

End of life care

Staff were committed to providing patients with an effective service that was person-centred and met their needs. There was effective multidisciplinary team working, which provided coordinated, joined-up treatment and care.

Patients benefited because there were end of life care pathways in use that ensured care was planned in a way that was able to meet the needs of patients and support their families.

We did not re-inspect this aspect of the service in February 2015.

Evidence-based care and treatment

- The palliative care liaison nurse and the Macmillan nurses provided specialist guidance to staff on the wards about end of life care.
- The Gold Standards Framework was in use on two of the wards we visited. It was about to be rolled out to other wards across the hospital. The standards set out how to care for people using evidence-based care and support.
- We saw that standardised end of life care pathways were in use, so that patients received

Pain relief

- The palliative care liaison nurse and the Macmillan nurses gave advice to the medical and nursing staff about appropriate pain relief when required.
- Staff confirmed for us that appropriate pain relief was discussed and prescribed, when needed, at daily ward rounds by the medical staff and other members of the multidisciplinary team on the wards that we visited. Patients and relatives told us the staff spoke to them to find out how they were feeling and if they were in discomfort.

Nutrition and hydration

- Patients we spoke with, spoke positively about the quality of food and drinks that they were provided with.
- Risk assessments and care records showed how to support people who were identified as being at nutritional risk. Fluid and food charts had been put in place to enable staff to monitor intake and output effectively.
- Specialist dietician support was available across the wards.

Patient outcomes

- In the National Care of the Dying Audit of Hospitals Pilgrim Hospital did not achieve the key performance indicators in five of the seven indicators.

Competent staff

- Staff told us that they were provided with appraisals and supervision of their overall performance at work.
- The end of life care nurses we spoke with told us they were supported and supervised in their work by one of the matrons at the hospital.
- There were learning facilitators on each of the wards that we visited, who provide training for staff.
- Staff told us that there were regular staff team meetings held. For those who could not attend, information was emailed to them or feedback was given via the matron or the ward sisters.

Multidisciplinary working

- Staff reported that there was effective multidisciplinary team working and decision-making relating to end of life care. For example, we were told that one person who was receiving end of life care was supported to go home with occupational therapy and physiotherapy support.
- The electronic palliative care coordination system meant that patients' records could be accessed when they were discharged from the hospital. This was to help ensure patients received a joined-up package of care from the different providers who were involved.

Seven-day services

- Physiotherapy and occupational therapy support was available at weekends, although this was a reduced service. One of the occupational therapy staff told us that their role included assessments to ensure patients who received end of life care had the equipment they needed to be able to go home.
- There was consultant presence that was on-call and out-of-hours, if needed.

Are end of life care services caring?

Good

Patients received care from staff that was attentive and sensitive to their needs. Patients and their families, that we spoke with, were positive about the care they received at the hospital. Patients we talked to described the staff as "caring" and "good fun".

We observed staff treating people with respect and saw that curtains were closed, to protect people's privacy and dignity, when personal care was being delivered.

End of life care

People we spoke with told us they were given sufficient information to be able to understand their treatment choices.

End of life care pathways were in place and care was planned in a person-centred way to ensure that patients received service that catered to their unique needs.

We did not re-inspect this aspect of the service in February 2015.

Compassionate care

- Staff assisted people with their care and treatment in a caring and sensitive manner.
- The Pilgrim Hospital had rooms available on-site for relatives of patients who were at the end of their life.
- Staff told us relatives were able to visit outside of normal visiting hours when patients were receiving end of life care.
- Staff ensured that privacy was maintained by staff when they assisted patients with their needs. We observed staff treating people with respect and saw that curtains were closed, to protect people's privacy and dignity, when personal care was being delivered.
- Patients and the families we spoke with were positive about the care they received at the Pilgrim Hospital.

Patient understanding and involvement

- Some patients knew about the 'named nurse's' system and some patients did not. They told us they spoke to the nurses about their care and were kept informed by them.
- Patients told us that they talked to the staff about their care and what help they felt they needed. The patients who we spoke with were not aware of being formally involved in writing a care plan for their needs. However, they told us that they felt able to talk to any of the staff about the care that they received.

Emotional support

- Clinical nurse specialists provided support and guidance for staff, in order to meet patients' needs.
- Patients' records included guidance that set out how to support them when they were anxious and/or low in mood.
- Patients and relatives told us that staff were supportive and made time to listen to them. We saw staff spend time with patients and their relatives who wanted to talk with them.

Are end of life care services responsive?

Good

The service patients received was planned in a way that was flexible to their needs. Staff told us that end of life care services were planned on the principle of person-centred care. This means that patients' wishes are at the centre of decisions made about their care. In 2014, only 17.5% of patients who died in the Pilgrim Hospital were seen by the palliative care team. In 2015, an additional palliative care nurse had been recruited, and the team had more capacity to visit a larger number of patients identified as having life limiting conditions.

A partnership had been formed with a local hospice to provide patients with a streamlined service when they were in the hospital and after discharge. The specialist palliative care team were provided with a varied training programme, to enable them to effectively meet patients' needs. Training courses focused on a range of outcomes for patients, including physical and emotional needs, as well as how to maintain dignity.

Service planning and delivery to meet the needs of local people

- An end of life care strategy had been implemented for use in the Pilgrim Hospital when patients were to be discharged. This was aimed at working in partnership with community services, including a local hospice, to provide a streamlined service for patients receiving end of life care.
- The service had formed a partnership with a local hospice and were working in partnership with them. This was to provide effective care for patients in the hospital and when they were discharged.
- In 2014, the trust data showed that 17.75% of patients who died between March 2013 and April 2014 were seen by the palliative care team. This meant that a high percentage of people who died in the hospital did not have access to this specialist service. In 2015, we found that an extra nurse had joined the palliative care team, and that increasing numbers of patients saw the team at the Pilgrim Hospital site.

End of life care

- The electronic palliative care coordination system meant that patients' records could be accessed when they were discharged from the hospital. This was to help ensure that patients received a joined-up package of care from the different providers who were involved.

Meeting people's individual needs

- Staff were able to explain to us how they meet the complex needs of patients on the wards. Care and treatment records provided detailed information, which set out how to effectively meet those patients' needs. Patients were not receiving end of life care on the days of our visit. Staff told us that when they did support patients receiving end of life care decisions were made with the patients' and relatives' full involvement, wherever possible.
- Translation services were available and there was a telephone translation service. We were also told that information could be given to people in different languages.
- Wards had been adapted to the needs of patients with dementia. Certain rooms had been painted bright, easily recognisable colours. There was a white board with the date on display. The Alzheimer's Society had an office at the services and gave support and guidance to patients on the wards we visited.
- The trust did not keep a record of how many patients had died in their preferred location.

Learning from complaints and concerns

- The staff were able to give us examples of how complaints and concerns had been acted upon on the wards that we visited. Patients were involved in devising the information packs that new patients were given about the hospital, as a result of a complaint.
- Complaints were responded to in accordance with the trust policy. If someone wanted to make an informal complaint they were directed to a senior member of staff. If this staff member was not able to deal with their concern satisfactorily, they would be directed to the Patient Advice and Liaison Service. If they still had concerns, people were advised to make a formal complaint. This process was outlined in leaflets available throughout the department and was depicted on multiple posters in other languages, if required.

Are end of life care services well-led?

Good

End of life care services were well-led at this hospital. We found that staff shared the visions and values of the trust, namely that the patients were at the centre of decisions made about how the service was run.

The views of patients and staff were being proactively sought to drive up standards at the service. Staff were positive about the way the leadership board was actively seeking their feedback.

Governance arrangements were in place to ensure that quality was effectively monitored and that there was learning from incidents, complaints and concerns.

Patients were supported by ward staff and the Patient Advice and Liaison Service so that they could easily make a complaint or raise concerns about the service.

We did not re-inspect this aspect of the service in February 2015.

Vision and strategy for this service

- The trust had a strategy for end of life care in place across the hospital. They were working in partnership with the local hospice to provide effective, joined-up working in end of life care.
- There were three consultants who specialised in end of life care, who were managed and appraised by the St Barnabas Lincolnshire Hospice medical director.
- Staff felt well supported by senior staff at the service. Staff reported that sisters and matrons led by example and were "hands on" with patients.
- The trust vision and values was on display on wards and along corridors in the hospital. The staff we met told us about this vision at focus groups and during one-to-one conversations.

Governance, risk management and quality measurement

- Governance systems were in place that ensured learning and improvements were shared across the service.
- Each ward visited displayed their quality dashboards, so that all staff understood what 'good looks like' for the service and what they were aiming for.

End of life care

Leadership of service

- Staff were positive in their views of the leadership of the wards they worked on.
- Staff who supported patients receiving end of life care, spoke positively about the role of the lead consultant who specialised in this area. One member of staff told us they had raised the profile of end of life care services, in a positive way.
- We saw that sisters and matrons took a hands on approach to care and acted as role models for the staff they led.
- Staff spoke positively about the new direction of the trust leadership boards. They reported that the leadership team were more visible to staff.

Culture within the service

- Staff reported that the culture of the trust had become more open and transparent. Staff were encouraged to air their views and said managers responded positively to them.
- Staff reported positive working relationships and we saw that they were respectful of each other, not only in their specialities, but across disciplines.
- Staff were positive about the service they provided for patients. They told us that ensuring they provided a patient-centred experience was seen as a key priority for everyone who worked in the Pilgrim Hospital.

Outpatients

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

Information about the service

Pilgrim Hospital outpatients department provides an outpatient service, with clinics held in the department throughout the week and on certain weekends. The clinics that run here include: urology services, fracture clinics for adults and children, dermatology, dental services for children, a breast screening unit, ENT and ophthalmology services.

The outpatients department also provided advice and support for a number of health conditions. There was also a 'support to stop smoking' service.

Summary of findings

The service was safe. There was a good culture of reporting and learning from incidents. The department was clean. Staff observed the bare below the elbows policy and were seen to wash their hands and use alcohol gel between treating patients.

Staff were seen to be caring and compassionate. Patients spoke highly about the medical staff and nurses they saw in outpatients.

The service was responsive to patients' needs. The average waiting times to be seen at the department or at one of the clinics was between five and six weeks. However, there were delays in the provision of breast screening, with 200 women's appointments being in breach of the two week target. The trust had identified this breach and had actions in place to resolve the issue.

The service was well-led. Staff were aware of the vision and values of the department and of the trust. Staff told us they felt consulted about decision-making and about the way the hospital was run.

Outpatients

Are outpatients services safe?

Good

Pilgrim Hospital outpatient department provides an outpatients service, and clinics that include a fracture clinic and urology

Patients spoke positively about the staff who assisted them, telling us that they felt safe with them.

There were governance arrangements in place, aimed at ensuring outpatient services were safe and suitable for patients and staff.

Staff received training to enable them to understand their role in maintaining and promoting health and safety at outpatient services.

Incidents

- The staff we spoke to told us that they would report incidents to a senior member of staff. They told us they received feedback from their department sister or matron. Incidents were also discussed at weekly meetings. The staff were able to give us examples of where practice had changed, as a result of incident reporting. For example, the location of one clinic had been moved in the department. This was because the previous location did not provide patients with enough confidentiality, due to its design.

Safety thermometer

- Health and safety audits were carried out and the results were displayed in the clinics.
- Areas for improvement were identified and checks were in place to ensure these had been carried out in a timely way.

Cleanliness, infection control and hygiene

- Clinical areas looked clean and we saw that the staff regularly washed their hands and used hand gel between patients.
- We saw that staff followed the bare below the elbow policy in the outpatients clinical areas.
- Toilet facilities were clean and we saw that they were checked regularly to ensure that cleanliness was maintained.
- Staff told us that they carried out hourly checks to ensure that the environment was kept clean and hygienic.

Environment and equipment

- The environment in the outpatient areas looked safe.
- Patients told us they felt safe with the staff working in the department.
- The waiting areas in the fracture clinic did not always provide enough seating if there was more than one clinic being run at the same time.
- Equipment was checked on a regular basis and was cleaned regularly, where needed, between patients. There was adequate equipment available in all of the outpatient areas.
- Resuscitation trolleys in the outpatient clinics were located in easy to access areas. Regular checks of the trolleys were carried out.

Records

- No issues were raised by staff about a lack of access to the full set of patients' notes. Staff we spoke with told us that patients' records were available for clinic appointments.
- Regular audits were carried out to monitor how records were stored and maintained.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The patients told us they were asked for consent and were given the information they needed to understand the treatment options available to them.
- Staff were able to explain to us how they would support patients who did not have capacity to consent to their procedure. The Mental Capacity Act 2005 was adhered to appropriately.

Safeguarding

- Staff had attended safeguarding training. The staff also understood what whistleblowing meant, if they felt they needed to raise concerns.

Mandatory training

- Staff told us they had been on regular mandatory training, including health and safety. The staff we spoke with had also been on training that was relevant to their role at the department.

Nursing staffing

- Staff told us there was no shortfall in the number of nurses employed to work in outpatients.

Outpatients

- We observed that there were nurses in each clinic who were attending to patients' needs.

Are outpatients services effective?

Not sufficient evidence to rate

Patients were positive about the treatment and the support they were receiving at outpatients.

Staff who worked at the outpatients department were committed to providing patients with a caring and attentive service.

On occasion, patients experienced delays for their appointments and there was a system in place to try and ensure that patients were given the appropriate information, at these times.

Evidence-based care and treatment

- The outpatients department had a clinical nurse lead who provided staff with clinical guidance and support in their work.
- Staff told us that they worked to local policies that were reviewed regularly, as part of the governance arrangements for the service.

Patient outcomes

- Patients gave positive feedback about the doctors who they saw in the clinics. Patients also had positive views to share with us about all of the staff who they saw.
- The service was not participating in any national audits that were specific to outpatients services. At trust-level, and at Pilgrim Hospital, audits were carried out on a number of areas. These included waiting times and record keeping.

Competent staff

- Staff were clear about what their role was and told us they were provided with support and supervision to ensure they were able to work effectively.
- Staff told us they were provided with regular appraisals of their overall performance.
- The service had a clinical educator who worked in the department, providing on the job clinical training.

Multidisciplinary working

- Multidisciplinary team clinics were held at the department. Specialists who worked there included: physiotherapists, occupational therapists, medical staff and nurses.
- Staff spoke positively to us about the effective multidisciplinary team working in the department. They told us there was an open team culture and they were able to make their views known to any of the other staff.

Seven-day services

- The senior sister informed us that, by arrangement, certain clinics were run on Saturday mornings and afternoons. This was planned when clinics were particularly busy during the week.
- Pharmacy services were available on Saturdays and Sundays and in the evenings.

Medicine

- We saw that medicines were stored correctly in locked cupboards or fridges. Records of fridge temperatures were maintained.

Are outpatients services caring?

Good

Patients spoke highly to us about the medical staff and nurses they saw in outpatients. They said staff were very caring, and one patient said they "can't do enough for you".

We observed that staff interactions with patients were respectful and attentive.

Staff were able to tell us how they maintained patients' privacy and dignity during their time in outpatients.

Compassionate care

- Patients feedback was positive about the attitude and approach of the staff they met at the outpatient department.
- We saw that patients were treated in a caring and respectful way by staff.
- Staff were able to give us examples of ways they ensured that patients' privacy and dignity was maintained. However, we observed that during busy

times there was a lack of privacy for patients who were checking in to reception at the fracture clinic. This was because there was nowhere private to check in for appointments, as the reception was in an open area.
- Curtains were always used when patients were seen for examinations. Sheets had been introduced into the department to protect female patients' dignity when they were examined.
- We viewed patient records and found they had been completed sensitively and they showed that discussions had taken place with patients and their relatives, where relevant.
- An hourly 'care round' had been introduced to check on the safety and wellbeing of patients who had not yet been seen for their appointment. Staff were able to give examples of how this was beneficial for patients. For example, one vulnerable patient had been observed and assisted by staff very promptly, due to these checks being carried out.

Patient understanding and involvement

- Patients told us that they felt that they had been involved in decisions regarding their care.
- Patients also told us they frequently saw locum doctors and this meant having to repeat what they felt was old information about their health.
- Information about advocacy services was displayed on notice boards in the department. These were for a number of different health conditions.

Emotional support

- Staff told us there was always a plan in place that included the use of a private room if patients were going to be given bad news about their health.
- Patients and relatives told us they had been treated in a respectful manner when they were told difficult diagnoses and had been given sufficient support.

Are outpatients services responsive?

Good

Patients were given the information they needed to plan their appointments and get to them on time. However the trust did not display delays in clinics and waiting times in a manner that patients knew that they were the most up to date information. There were delays in the breast screening clinic which the trust was aware of but this had an impact on the women who were waiting. Patients were positive in their views of the staff and how they responded to their particular healthcare needs.

There were systems in place to ensure that patients were kept fully informed when there were delays in waiting times.

Complaints and concerns were responded to in a positive manner .There were systems in place to enable people to make their views known about the service they had received.

Service planning and delivery to meet the needs of local people

- Delays in clinics and waiting times were displayed, but they were not timed and dated, so it was not clear if this was the most current information or not.
- A number of the patients told us their appointment times were running late. However, they also told us that staff from their clinic and the department had made them aware of this and kept them informed.
- The staff told us that they supported patients through busy times, by ensuring they communicated with them and told them what the waiting times were. Reasons for why clinics were running late were given, where appropriate.

Access and flow

- Patients told us they were sent out an initial letter with a map of the hospital. The patients we spoke with told us there was frequently a shortage of car parking spaces for afternoon clinics.
- A system of automatically booking in for appointments had been introduced. This could be done in six different languages.
- The average waiting times to be seen at the department or at one of the clinics was between five and six weeks.
- The practice of double-booking appointment times was not formally reviewed. As a result, it was not clear if this had had an impact on the time that patients had to wait for an appointment or on the numbers of appointments that were cancelled.
- There were 200 women whose appointments were in breach of the two week waiting time target for breast screening. The trust had identified this breach and told us they were actively trying to recruit an additional full-time radiographer, to address this shortfall in their screening services.

Outpatients

- The average waiting time for a first outpatient appointment was audited as being between five to six weeks over the 12 months prior to our inspection

Meeting people's individual needs

- Patients gave us positive feedback about how doctors and other staff at the department and the clinics met their individual needs.
- There was a visual and hearing-impaired support service available and this was clearly advertised for patients.
- Patients could also access the translation telephone service available, or interpreters.
- Written information was available in several languages and large print.
- Wheelchairs were available at the entrance to outpatients.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Initial complaints would be dealt with by the senior sisters in charge of each clinic. If they were not able to resolve concerns, people would be referred to the Patient Advice and Liaison Service. If the Patient Advice and Liaison Service were not able to address their concerns, people were advised to make a formal complaint. This process was outlined in leaflets available throughout the department and was displayed on posters in the department
- The senior sisters produced a monthly newsletter, which was emailed to staff and detailed any recent concerns.

Environment

- Car parking was not easily available and there was no free waiting time for outpatient appointments, irrespective of the length of time patients waited for their appointments. Patients told us this was frustrating.
- There was a children's play area with toys. However, the fracture clinic did not have a children's play area.
- Staff reported that the dermatology clinic procedure area could get excessively hot. However, this was being monitored by designated health and safety staff.
- There was a coffee shop in the main reception area with snacks and hot and cold drinks.
- Seats were comfortable.

Are outpatients services well-led?

Good

Staff were aware of the visions and values of the department and of the trust. Staff told us they felt consulted about decision-making about the way in which the Pilgrim Hospital was run.

There were arrangements in place to ensure that the overall quality of the services at outpatients were effectively monitored.

The views of patients and staff were actively sought by the managers of the department and by the trust leadership team.

Staff reported that they felt well supported in the department by the sisters and matrons.

Vision and strategy for this service

- We saw that the trust vision and values were prominently displayed throughout the OPD and corridors.
- Staff had a good understanding of the vision and values and showed this in their actions.
- Staff told us that the vision for the service was to ensure that care and treatment was delivered in a person-centred way. This meant aiming to ensure that the needs of patients were always put first.

Governance, risk management and quality measurement

- Text messages were sent to patients (if this was their preferred choice) after attending the outpatients department in order to seek their views as part of NHS Friends and Family Test feedback.
- Staff reported that regular governance meetings were held within the directorate and they were encouraged to attend. Feedback was given to staff who did not attend staff meetings via emails. Staff used these meetings to discuss complaints, incidents and quality improvement project matters.
- A quality dashboard was on display for staff to see what 'good looks like' for the service and what they were hoping to aim for in different areas of the service.

Outpatients

Leadership of service

- The staff were positive and felt supported by the leadership they received from the clinic and department sisters.
- There were two matrons who managed the departments in outpatients. Staff told us that there were regular meetings held with the matrons and other senior staff. This was to ensure effective communication and decision-making in the department.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.
- Staff told us openness and honesty was the expectation in the department and was encouraged by managers, for all staff.
- Staff told us they worked well together and we observed respectful interactions between the specialities and across disciplines.

Public and staff engagement

- Notices were displayed at the entrance to outpatients, inviting staff and patients to give feedback to the leadership team about the service they received.

Innovation, improvement and sustainability

- The staff felt that their views and ideas were sought from senior staff across disciplines. Nurses were able to give us examples of practice that had changed as a result of their suggestions and innovation.

Outstanding practice and areas for improvement

Outstanding practice

- The involvement of a former patient, who had previously complained about their care and treatment, in the recruitment process for new staff in the Patient Liaison and Advice Service (PALS) team.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Ensure that all patients are treated with dignity and respect, and that care meets their individual needs, especially those patients who may have a lack or diminished capacity.

Action the hospital SHOULD take to improve

- Review pathways for paediatric patients to receive treatment that meets their needs, and is in line with current guidance in respect of cystic fibrosis and cerebral palsy.
- Review mechanisms for ensuring that documentation reflects patients nutritional and hydration intake.
- Take steps to inform patients of the key quality initiatives in maternity services.
- Continue to take steps to address performance times, in respect of patients getting timely treatment in surgery.
- Continue to review the risks associated with children requiring a higher level of care, to ensure their safety.