

United Lincolnshire Hospitals NHS Trust

Lincoln County 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

Good



Surgery

Requires improvement



Critical care

Good



Maternity and family planning

Good



Services for children and young people

Good



End of life care

Good



Outpatients

Inadequate



Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection because United Lincolnshire Hospitals NHS Trust (ULHT) had been identified as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. The trust was one of 11 trusts placed into 'special measures' in July 2013, after Sir Bruce Keogh's review (Keogh Mortality Review) into hospitals with higher than average mortality rates.

We inspected Lincoln County Hospital, Pilgrim Hospital, Grantham and District Hospital, and County Hospital, Louth. We did not inspect the other services provided at John Coupland Hospital, or Skegness and District Hospital, as these are not operated as part of the acute sites. The announced inspection took place between 29 April and 2 May 2014, with an unannounced inspection visit on Sunday 11 May 2014. We returned in February 2015 and inspected only those key questions where the service had been rated as requiring improvement or inadequate. We did not undertake a full comprehensive inspection on 2 February 2105.

In 2014, this trust was found to require improvement, although we rated it good in terms of having caring staff. Core services for accident and emergency (A&E), medicine, surgery, maternity, children and young people, and end of life care, were found to require improvement. The outpatients department required urgent improvements to be made to ensure that it was safe and responsive to patients' needs, and the leaders of this service were required to improve the service. When we returned in 2015, we saw that significant improvements had been implemented, and that all services, except for surgery and outpatients, had improved, and were rated as good. Surgery required some further improvements in both safety and responsiveness. Outpatients still required significant and urgent improvements in the partial booking system.

Our key findings 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.
- Recruitment and retention was still a challenge for the hospital, and for the trust as a whole.
- Medication errors were now well reported within the trust.
- Infection control procedures within surgery required improvement.
- A new 'front door frailty service' had been commenced, which had been proven to be successful.
- Stow Ward was no longer in use. This ward had been closed, and a new ward, Shuttleworth, had been opened. We saw significant improvements had been made in culture, staff attitudes and the caring nature of the ward.
- We found that mandatory training and annual appraisals had not reached the targets set by the trust, and therefore required further improvement.
- The new head of midwifery had led significant initiatives and improvements since May 2014.
- Mental capacity was not always considered or documented appropriately, especially when decisions around DNA CPR are made.
- Staff appraisal rates across nursing teams were improving, but still required improvement.
- Referrals to the specialist palliative care team had improved, as had training and awareness, following the previous inspection and the appointment of link nurses on each ward.
- The previous disconnect between the team and senior managers was no longer apparent, as staff within the specialist palliative care team now felt well supported by the trust.
- Medical records had improved significantly, and were available to outpatient clinics.
- The outpatients department was crowded, overbooked, and waiting times were lengthy.
- On review of the new outpatient booking system, combined with the change-over to a new patient administration system (PAS), the trust did not have validated numbers of how many people were awaiting appointments, and the risk of patients becoming lost in the system remained.

Summary of findings

We saw several areas of outstanding practice including:

- Gender separation in the intensive care services.
- People who had complained were invited to take part in recruitment and selection processes for posts in the Patient Advice and Liaison Service (PALS) team.

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

Importantly, the trust must:

- Ensure that patients receive treatment and care in a timely manner, particularly within the outpatients departments.
- Ensure that medical staff review the level of capacity of patients when reviewing resuscitation decisions, to ensure that patients who may lack capacity are protected when these decisions are made about their care.

In addition the trust should:

- Continue improvements to ensure that patient waiting times in outpatients reduce to an acceptable level.
- Review arrangements to ensure that staff undertake mandatory training and appraisals, to ensure that the staff are competent to undertake their roles.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Accident and emergency

Rating

Good



Why have we given this rating?

In 2014, the A&E department at Lincoln County Hospital required improvement to ensure that services were safe and responsive to the needs of the patients being treated at the hospital. Clinical and reception areas had recently been refurbished, with majors and resuscitation bed capacity increased. Incident reporting was completed, with a clear 'lessons learned' approach. We looked at equipment, which was maintained to the manufacturer's recommendations, was clean and in date. Medication was recorded and stored appropriately, with daily checks carried out by qualified staff.

At times, the department was very busy, and patients were held temporarily within the ambulance handover area. There was a senior member of the nursing staff who was designated as a shift co-ordinator who managed and kept the patient waiting time to a minimum within this area. In 2015, we found that there were systems and processes in place to ensure that this was effective. We looked at staff training records. All staff had received mandatory training, including safeguarding adults and children. Mental capacity assessments were being undertaken appropriately, and staff demonstrated knowledge around the trust's policy and procedures. Staff took the time to listen to patients, and explain to them what was wrong and any treatment required. Patients told us they had all their questions answered and felt involved in making decisions about their care. The staff we spoke with were proud to work for the A&E department and felt there was a 'can do' attitude within the multidisciplinary team.

The leadership team within the department demonstrated innovation, and encouraged learning and listening across all grades of staff. However, in 2014 we saw little impact of the risk planning to address the issues in responsive and safe domains. In February 2015, we found that risk management had improved and saw minutes of previous meetings held since our inspection in May 2014.

Summary of findings

Medical care

Good



In 2014 we found that services for medical care were safe and effective, because there were systems in place to identify, investigate and learn from incidents and complaints. Ward staff assessed patient risks for falls and pressure ulcers, and put in place plans of care to reduce these risks. There were processes to identify if patients were deteriorating. We found that staff were caring and compassionate, and meeting patients' individual needs. There were effective stroke and cardiac services being run according to evidence-based guidelines. We saw innovative practice on Burton Ward, which had been adapted to meet the needs of patients with dementia. The wards were well-led, and there was good communication between the executive team and staff on the wards.

We received some information of concerns about the cardiology service at the trust before we carried out our follow-up inspection in February 2015. We looked at the cardiology service being provided at the hospital. We did not identify any concerns about the service being provided at Lincoln County Hospital.

In February 2015, qualified nurse vacancies in some areas were high; there was regular use of bank and agency nurses in these areas. Medicines were being stored and administered effectively, and staff had received training on the effective use of the sepsis care bundle. Mortality rates for the trust were within expected limits, and junior medical staff felt supported and were able to access planned training sessions.

Medical outliers on surgical wards could cause a delay in treating elective surgical patients. A new 'front door frailty service' had been commenced, which had been proven to be successful.

Refurbishment of two medical wards caring for older people had yet to be commenced to reflect the needs of patients with a dementia. Lessons were being shared within the medical directorate across the trust. The executive team was more visible, although while some staff were confident about speaking out about concerning issues, others were too frightened to do so for fear of reprisals.

Surgery

Requires improvement



In 2014 we found that care provided was not always safe and did not always meet the needs of the

Summary of findings

patient, particularly when it came to bowel care. We identified multiple medication errors at prescribing and administration stage. These were not consistently reported so that staff could learn and actions could be taken to reduce the risk of reoccurrence. The management team for the surgery service assured us that they would implement immediate improvements in these areas and maintained that they had clinically reviewed all patients identified at risk of bowel concerns. They also told us that they had conducted additional medication audits during our inspection to resolve concerns. These concerns were reviewed on our unannounced visit. In 2015 we reviewed these areas again and noted continued improvements. Services were provided in a clean and hygienic environment, in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections. In the majority of wards we saw staff that were caring. The patients we spoke with complimented staff on their caring approach and professionalism. However, we identified that staff on Stow Ward were not always caring, did not always respond to patient's needs, and did not always treat patients with dignity or respect. We discussed this with senior managers, who put systems in place to ensure patients' needs could be met. When we returned on our unannounced visit, we found that these had remained in place and patients reported good care on this ward. In 2015, Stow Ward was no longer in use. This ward had been closed and a new ward, Shuttleworth, had been opened. We saw significant improvements had been made in culture, staff attitudes and the caring nature of the ward. Gaps in staffing were met using bank (overtime) and agency staff, but such staff were not always available. The trust has a recruitment programme; however, staffing levels within the surgery areas were low at the time of our inspection, based on the level of acuity seen in the wards. The management team of the surgery service assured us that they would provide additional staff where patient acuity changed, but they had some difficulties ensuring that bank or agency staff turned up. In 2015, recruitment and retention was still a challenge for the surgery division and for the trust as a whole. We

Summary of findings

found that this was however being managed effectively, and recruitment drives and initiatives were still regularly taking place. A recent uplift in staffing had also been agreed.

Our findings in 2015 demonstrated that the surgery division at this hospital had worked extremely hard in making positive changes to improve the service provided to its patients. Ratings improved in four out of the five areas. However, improvements are still required, and these relate to infection control procedures, maintaining a safe environment, medicines management, application and understanding of the Mental Capacity Act, and capacity and demand on the service.

Maternity and family planning

Good



In 2014 we found that the maternity service was caring. We received positive feedback from the majority of women that we spoke with. We were told that the service understood women's emotional needs and that staff demonstrated a caring attitude, while care and treatment was being provided. The service was responsive to people's needs. We found that clear pathways were in place to deal with women's individual needs and that the service could be flexible to deal with demands. The service had a good incident reporting culture and staff were aware of the key risks within the service. We found a similar picture at our inspection in 2015.

However in 2014, improvements were needed in relation to staffing, staff support and leadership of the service. The maternity services were not working in line with national recommendations in relation to the numbers of maternity staff on shift. There were risks within the service, which meant that, on occasions, staffing levels were such that they did not promote safe care. Community midwives were also not staffed in line with current recommendations. Improvements were needed to ensure staff were appropriately supported. We found that mandatory training and annual appraisals had not been completed by a high proportion of staff within this service. At our inspection in 2015, we found that whilst the leadership had improved under the new head of midwifery, there were still improvements required in relation to midwife staffing and training, in order that the hospitals unit was in line with national and local targets. The trust had previously

Summary of findings

identified the presence of asbestos in the maternity buildings 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. In 2014 we found that while there were good systems of governance in place, we found that staff had not identified key risks and escalated these through a risk register. There was no clear vision in place for the service, and staff were not clear about how they kept up to date with developments within maternity. During our inspection in 2015, we found that a new head of midwifery (HOM) had been appointed across the trust in August 2014. Staff we spoke with were positive regarding the current leadership, and the strong focus on governance and risk management since this appointment. We found the service to be well-led and effective; however, safety in the maternity unit at Lincoln County Hospital required further improvement, although developments had been made in some areas since the last inspection in May 2014. There had been numerous initiatives and improvements since May 2014, including the development of a monthly Trust Governance Team meeting followed by a Trust Business Unit/Senior Nursing and Midwifery Team meeting, to improve communication and manage risk more effectively across the hospital sites.

Services for children and young people

Good



In 2014 we found the paediatric service was caring. We received positive feedback from the majority of children and parents that we spoke with. We were told that staff demonstrated a caring attitude, while care and treatment was being provided. The service had a good incident reporting culture, and staff were aware of the key risks within the service. When we visited in 2015, the people we spoke with told us that they could not fault the service. Throughout our inspection in 2014 we found that improvements were needed. We noted that the service was not staffed in line with current recommendations issued by the Royal College of Nursing (RCN). The service was also caring for patients with high dependency needs, which it was not commissioned for. This was

Summary of findings

impacting on the level of staff available to care for routine patients within the service. In 2015, we found 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.

In 2014, we found that evidence-based care pathways were lacking, and that equipment was not always checked appropriately. In 2015, we saw that evidence-based care pathways were being used, and that equipment had been checked and was safe to use.

In 2014 we found that improvements were needed to ensure staff were appropriately supported. We found that mandatory training and annual appraisals had not been completed by a high proportion of staff within this service. A clinical supervision programme was also not in place. In 2015, we reviewed these areas again, and saw some improvements had been made. There were, however, some areas that required continued improvement.

End of life care

Good



The specialist palliative care team provided positive information and advice to general ward staff on the care of the dying patient. However in 2014, the service was not well developed, and there was a disconnect between what managers wanted to happen and what some of the palliative care team were undertaking. Patients using the service had only praise for the staff and felt involved in their care. At our inspection in 2015, we found that this disconnect was no longer apparent, as staff within the specialist palliative care team now felt well supported by the trust. The team had begun to use patient demographics to drive service delivery and training, and implementation of palliative care link nurses was well underway.

In 2014 we stated that improvements to the service, in terms of ensuring that the overarching strategy was accomplished, addressing challenges within the completion of the 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) form, and the training of nursing staff on general wards, were required to ensure a safe, effective and responsive service. However, at our inspection in 2015 we found that significant improvements to training and overarching strategy had been implemented. The

Summary of findings

completion of DNA CPR forms still requires further improvement to ensure that patients who may lack capacity are protected when these decisions are made about their care.

Outpatients

Inadequate



In 2014 we found that patients received good care; the systems to support the service were judged to be inadequate. The lack, and condition, of medical records, training of staff, and issues with the building, needed addressing by the hospital. The department was very busy and did not have enough space for all clinics. This meant that some clinics could not provide a service other than in routine hours. Cancellation of appointments was a frequent occurrence and this was due in part to lack of medical records. The new outpatient booking system was not generally well liked by staff or patients, as they felt that their appointment would be lost in the system.

Staff were aware of the risks, and they took daily action to mitigate these. The overcrowding and overbooking of clinics was a significant issue for patients. Information was provided to patients through leaflets and posters on the walls. However, access to magazines and books were limited. Cancellations, car parking charges (excessive due to long waits) and waiting times were amongst the most frequent complaints from patients.

In 2015, we found some improvements with the condition of medical records; however, the issues regarding space and capacity for outpatients remained a concern. The trust has shared with us their plans to increase the physical capacity and improve the environment for patients.

Appointments were frequently cancelled, and for those specialties where demand exceeds capacity clinics were routinely overbooked. The change-over to a new patient administration system (PAS), the trust did not have validated numbers of how many people were awaiting appointments, and the risk of patients becoming lost in the system remained. Overcrowding and overbooking of clinics remained a significant issue for patients. Car parking charges (excessive due to long waits), and waiting times were amongst the most frequent complaints from

Summary of findings

patients. Most patients we spoke with about car parking charges raised concerns, and we identified that this appeared to have not improved since our inspection in 2014.

Requires improvement

Lincoln County 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; Outpatients

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Detailed findings

Background to Lincoln County Hospital

The United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest trusts in the country. Lincoln County Hospital has 602 beds and provides a range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services to the 700,000 people of Lincolnshire.

The hospital was originally built in 1776 and designed by John Carr. The hospital has been rebuilt with the oldest part, maternity built in 1966, and the majority of the hospital built in the 1980's. The hospital areas are joined by corridors which have access to green, open spaces. The trust has not applied for foundation trust status and is currently in special measures following the Keogh Mortality Review in 2013. This is the primary reason for inspecting this trust, as it is one of the highest risks, as identified by the CQC intelligent monitoring.

Lincolnshire is a largely rural area, with only 27 miles of dual carriageway in the county. This makes travel times lengthy, and road injuries/deaths are common. In Lincolnshire, traffic-related injuries/deaths are significantly worse than the average for these types of injuries in England. The county's average of Black, Asian and minority ethnic (BAME) residents is lower than the English average – with the largest ethnic group being Asian (1.2%). There are medium levels of deprivation, but these levels have increased since 2007. The county has an ageing population, with a higher than average number of older residents. 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. 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 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 the range of information we held 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, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the royal colleges and the local Healthwatch.

Detailed findings

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.

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 carried out unannounced inspections between 3pm and 10pm on Sunday 11 May at this site. We looked at how the hospital was run at night, the levels and type of staff available and how they cared for patients.

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 Lincoln County Hospital.

Facts and data about Lincoln County 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

Detailed findings

- 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%
- 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	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Maternity and family planning	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients	Requires improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
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 both Accident and emergency and Outpatients.

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 accident and emergency department (A&E) at Lincoln County Hospital provides a 24 hour, seven-day working service to the local area. The department sees around 70,000 patients a year, and has recently undergone refurbishment within the reception, minor, major and resuscitation areas.

Patients present to the department either by walking in via the reception area or arriving by ambulance. The department had facilities for assessment, and treatment of minor and major injuries within fifteen cubicles, a new four-bed resuscitation area and a children's service. The department included a separate ambulatory care service for patients walking into the department or referred by a primary care service, for example, a GP.

Our inspection included three days in the A&E department as part of an announced inspection. During our inspection, we spoke with clinical and nursing leads for the department. We spoke with five members of the medical team (at various levels of seniority), seven members of the nursing team (at various levels of seniority) including the lead nurse for ambulatory care service, two members of the reception staff, and the lead for clinical governance for the department. We also spoke with five patients and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for patients in the A&E department. When we returned to inspect the accident and emergency department on 2 February 2015, we spoke with five members of the

nursing team, including two senior nurses, and three members of the medical team, including the lead consultant. We spoke with six patients and observed care being delivered.

The ambulatory care service has reduced admissions into the medical emergency assessment unit (MEAU) pathway by approximately 10%. On average, the A&E department saw over 70,000 patients a year, which equated to around 1,500 patients a week. During the four-week period from 1st March 2014 to 1st April 2014, the department saw 6,135 patients. The trust's performance with regards to the four-hour waiting times is inconsistent, and they are regularly not meeting the target of 95% of patients being seen and either transferred, admitted or discharged within the four-hour target. The number of patients admitted to a ward was 1,692. This equated to an admission rate of 27.6%. During our inspection on the 2 February 2015, we saw that the ambulatory care area had been enhanced, with the building work completed.

The A&E department is a member of a regional trauma network. The hospital also provides acute stroke services, and primary intervention for acute heart attacks.

Accident and emergency

Summary of findings

In 2014 the A&E department at Lincoln County Hospital required improvement to ensure that services were safe and responsive to the needs of the patients being treated at the hospital. Clinical and reception areas had recently been refurbished with majors and resuscitation bed capacity increased. Incident reporting was completed with a clear 'lessons learned' approach. We looked at equipment, which was maintained to the manufacturer's recommendations, was clean and in date. Medication was recorded and stored appropriately, with daily checks carried out by qualified staff.

At times, the department was very busy and patients were held temporarily within the ambulance handover area. There was a senior member of nursing staff who was designated as a shift co-ordinator who managed and kept the patient waiting time to a minimum within this area. In 2015, we found that there were systems and processes in place to ensure that this was effective.

We looked at staff training records. All staff had received mandatory training, including safeguarding adults and children. Mental capacity assessments were being undertaken appropriately and staff demonstrated knowledge around the trust's policy and procedures. Staff took the time to listen to patients and explain to them what was wrong and any treatment required. Patients told us that they had all their questions answered and felt involved in making decisions about their care. The staff we spoke with were proud to work for the A&E department and felt there was a 'can do' attitude within the multidisciplinary team.

The leadership team within the department demonstrated innovation, and encouraged learning and listening across all grades of staff. However, in 2014 we saw little impact of the risk planning to address the issues in responsive and safe domains. In February 2015, we found that risk management had improved, and saw minutes of previous meetings held since our inspection in May 2014.

Are accident and emergency services safe?

Good



In 2014, the A&E department at Lincoln County Hospital required improvement to ensure that patients were safe. These areas included infection prevention and control issues, and health and safety issues, as well as a lack of space for confidential discussion between staff handing over patients. Patients observations were not recorded in a timely manner and so could potentially impact on the care given. There were adequate staffing levels to provide safe care to patients, apart from paediatric nurses, which were limited. Staff were aware of the challenges within the department regarding children's service provision, and were working towards addressing those challenges with training and recruitment. However, at the time of our inspection, we were not assured that the service was safe for all patients.

During our inspection on the 2 February 2015, we found improvements had been made with the introduction of safety quality dashboards, improved infection prevention and control awareness, and new procedures were in place. We saw that staffing levels had improved and, in particular, the provision of paediatric nurses within the department. We saw improvements with regards to the safe storage of patient clinical records during our inspection in February 2015, and we saw a new central clerking area for both doctors and nurses. We looked at the management and storage of medicines, which had improved, and staff handled medication in accordance with trust policy.

Incidents

- The trust reported 66 Serious Incidents (SI) to the National Reporting and Learning System (NRLS) relating to the three A&E departments between March 2013 and February 2014.
- In addition, the trust provided us with the A&E incident listing reports. In total, 277 incidents were reported, regarding events that occurred both internally and externally. Three of these resulted in death or stillbirth, and 12 in severe harm.
- Staff told us that they reported incidents via the hospital internal reporting system, but received poor feedback

Accident and emergency

on incident outcome and closure on incidents they personally reported. In February 2015, we spoke with four members of staff, who told us they had received feedback on the outcome of the incidents they reported, including closure. One member of staff told us that there was an improved focus on incident reporting, and they felt that when they submitted an incident report it received a timely response and feedback.

- We saw evidence of learning from an incident while observing within the A&E department and this was discussed within the management team and staff involved.
- The department holds monthly mortality and morbidity meetings, with clinical and nursing staff attending.

Cleanliness, infection control and hygiene

- During our inspection in 2014, we observed limited personal protective equipment practice, whereby not all staff were witnessed to be wearing gloves or washing their hands between patients. During our inspection on 2 February 2015, we saw consistent infection prevention and control practices being carried out, and staff washing their hands between patient care being provided. Gloves and aprons were disposed of appropriately prior to completing any documentation.
- We observed maintenance staff using a dressing trolley and paediatric treatment trolley to transport their tools within the major's treatment area while carrying out repairs. We did not see any warning signs to warn staff or visitors of maintenance work being carried out.
- The trust's infection rates for *C. difficile* and MRSA infections lay within a statistically-acceptable range for the size of the trust.
- During our inspection in 2014, we noted that there were limited hand-cleaning stations within the majors and minors treatment area outside of patient treatment cubicles. Hand sanitiser was found behind the computers, out of view. We observed ambulance staff remove dirty linen and clean ambulance stretchers within the same area that patients were handed over. We could not see a specific area identified for this. In February 2015, we saw that each patient cubicle had a hand cleaning station, and the department was trialling a new hand sanitiser. Hand sanitiser was mounted on walls and clearly identified. Computer work stations were clear, and ambulance staff had a designated space, whereby they could replenish clean stock from a closed store cupboard within the new central staff base.

Environment and equipment

- The A&E department had recently undergone a refurbishment prior to our inspection in 2014, within some areas, which had improved the reception area, majors and minors treatment areas, and the resuscitation area. At our inspection in February 2015, we saw that the ambulatory care service had relocated and building work had finished. Staff told us that the environment was good, although it could be bigger due to the success of the ambulatory care services.
- The resuscitation area had recently been refurbished and increased in bed space, which came into use on the week of our 2014 inspection. The area was clean and bright. Resuscitation equipment was available and clearly identified with equipment trolleys following a system that adopted an airway, breathing and circulation management approach within each resuscitation bay, and a specific children's equipment trolley.
- Treatment cubicles were clean and well-equipped, with appropriate lighting.

Medicines

- We checked the records and stock of medication, including controlled drugs, and found them to be correct, with concise records detailing appropriate daily checks carried out by qualified staff permitted to perform this task.
- In 2014, we pathway-tracked a patient who had been admitted to a ward via the A&E department and found within their notes that an A&E medication prescription was poorly completed and not signed by an A&E doctor, which delayed administration of the medication to the patient.
- During our inspection in February 2015, we looked at eight sets of patients notes and, in particular, drug prescription charts. We found all drug prescription charts fully completed, with appropriate doctor authorisation. Patients were receiving their medication on time and when required.

Records

- Within the A&E, we saw notes that risk assessments were undertaken in the department when patients were there for some time (it is recommended by the Royal College of Nursing that if patients are in an area for longer than six hours, a risk assessment for falls and pressure ulcers should be completed).

Accident and emergency

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable about how to support patients who lacked capacity. They were aware of the need to assess whether a patient had a temporary or permanent loss of capacity and how to support patients in each situation. If there were concerns regarding a patient's capacity, the staff ensured the patient was safe and then undertook a mental capacity assessment.
- According to the A&E mandatory training database, all nursing and medical staff have undergone mental capacity training.
- We observed nursing and medical staff gaining consent from patients prior to any care or procedure being carried out.

Safeguarding

- The A&E department had champions within the department and in particular a champion for safeguarding of vulnerable adults and children.
- We looked at training records and saw that all nursing and medical staff had undergone mandatory safeguarding training at level 2.
- All safeguarding concerns were raised through a centralised reporting system. The concerns were reviewed at a senior level to ensure a referral had been made to the local authority's safeguarding team.
- The staff we spoke with were aware of how to recognise signs of abuse and the reporting procedures.

Mandatory training

- We were provided with comprehensive records of mandatory and supplementary training for all nursing and medical staff, with 98% compliance across the multidisciplinary teams.
- Mandatory training was provided in different formats including face-to-face classroom training and e-learning (e-learning is electronic learning via a computer system), although staff told us that there was limited time allowed to complete e-learning. This meant that sometimes they had to complete the e-learning at home.

Management of deteriorating patients

- In 2014 we looked at over 10 sets of notes during our inspection. Three of the sets of notes highlighted delays in the recording of patient observations. One patient arrived in the department via ambulance, and did not have an initial recording of observations for two hours

and 37 minutes. Another set of notes showed a delay of 25 minutes for the first set of observations to be recorded, with the third set of notes showing a delay of 43 minutes for observations to be recorded.

- In February 2015, we looked at eight sets of patient notes, and found observations were recorded within fifteen minutes of arrival, and at regular intervals. We saw that two patients required observations at more frequent intervals, and that this was consistently carried out and recorded.
- The A&E department operated a 'track and trigger' alert system in 2014, whereby nurses enter the patients' clinical observations into their notes. The system then provides a score and is used to alert clinicians of any deterioration in a patient's condition.
- At our inspection in February 2015, we saw that the accident and emergency department had moved to the national early warning scoring (NEWS) system and the paediatric early warning scoring (PEWS) system from the 'track and trigger' 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.)
- We observed that the department operates a triage system of patients presenting to the department either by themselves or via ambulance, and patients are seen in priority dependent on their condition. During our inspection, we pathway-tracked two patients and found that neither of them were seen by a clinician within 20 minutes of arrival into the A&E department. However, all other patients that we observed within the triage area were seen within the required time of 20 minutes.
- Patients arriving as a priority (blue light) call are transferred immediately through to the resuscitation area. Such calls are phoned through in advance (pre-alert), so that an appropriate team are alerted and prepared for their arrival.
- In 2014, we looked at seven pre-alert forms, and found that four of the forms had not been completed fully with any clinical observations recorded, estimated time of arrival of the ambulance to the A&E department, or who took the details over the telephone from the ambulance service.

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- In February 2015, we looked at the pre-alert system used, and found that the department was using the 'ATMIST' acronym, which provides an alert including the patients Age, Time, Mechanism, Injury, Signs and Treatments. The three forms we looked at were consistently completed, and we spoke with two staff members who explained the system in detail.

Nursing staffing

- Information provided by the trust indicated that the establishment for the A&E department was not operating at the required whole time equivalents (WTE), with 5.25 of qualified nurse posts vacant in 2014. Senior staff acknowledged that they were looking at the RCN 'BEST' policy to understand their staffing needs. During our inspection on 2 February 2015, we saw that the department had used the RCN 'BEST' acuity tool, and the whole time equivalent (WTE) of staff had increased by 7 members of staff.
- In 2014, the department only had a limited whole time equivalent of 1.4 nurses with specific paediatric qualifications. When they were on shift they would be assigned to the paediatric service within A&E. However, this was not staffed by appropriately-trained nurses at all times. In recognition of this, there was a business case signed off to recruit child-trained nurses, and the department was putting in place a training programme to upskill the adult nurses.
- In February 2015, we saw that the provision of paediatric nurses had increased by 2.6 of (WTE), and the department was actively recruiting child-trained nurses. We were told by a senior nurse that nurses had been trained in paediatric immediate life support (PILS). We spoke with three members of staff who confirmed that they had received PILS training.
- The department had introduced a bespoke accident and emergency module for adult nurses to upskill to provide a paediatric provision on all shifts.
- We observed that there was a professional handover of care between each shift.
- All bank and agency staff received local induction prior to starting their shift.

Medical staffing

- The department currently has three whole time equivalent (WTE) consultants out of 12 posts who are present in the department from 8am until 9pm. There are middle grade doctors and junior doctors overnight with an on-call consultant system.

- There was a high use of locum consultant and middle-grade doctor services, in particular at weekends, and the senior management team are aware of this. We looked at the doctor's rota and saw that the locum consultant and middle-grade doctor use was consistent in using the same doctors who had received the trust induction programme and were familiar with the department and protocols.
- Consultant hours were depleted at weekends and the department was challenged to provide the required 16 hours of consultant service within the department.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

We report on effectiveness for Accident and Emergency, however, we are currently not confident that we are collecting sufficient evidence to rate effectiveness for Accident and Emergency. We found that the department policies and protocols were based on national guidance. The new protocol for bundles of care was implemented but not yet embedded. There was good multidisciplinary working.

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

Evidence-based care and treatment

- Departmental policies were easily accessible and staff were aware of them and reported that they used them. There was a range of A&E protocols available, which were specific to the A&E department.
- Further trust guidelines and policies were available within the A&E department. For example, sepsis and needle stick injury procedure. We saw treatment plans that were based on the National Institute for Health and Care Excellence (NICE) guidelines.
- We found reference to the College of Emergency Medicine (CEM) standards and spoke with medical staff who demonstrated knowledge of these standards.
- There was a clear protocol for staff to follow with regards to the management of stroke, fractured neck of femur

Accident and emergency

and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six was the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. This had recently been introduced and was yet to embed.

Nutrition and hydration

- The department undertook regular food and drink rounds 24 hours a day, seven days a week.

Patient outcomes

- Although we were informed that the department took part in national College of Emergency Medicine audits, they were unable to provide us with the results of these or evidence that they had used the results to assess the effectiveness of their department.
- The College of Emergency Medicine recommends that the unplanned readmission rates for A&E should be between 1-5%. The national average is around 7%, which the trust has performed well against since January 2013. Their rate in November 2013 was 6%.

Competent staff

- 93% of the appraisals of both medical and nursing grades were undertaken and staff spoke positively about the process and that it was of benefit.
- We saw records that demonstrated 100% of both medical and nursing staff were revalidated in basic, intermediate and advanced life support.

Multidisciplinary working

- We witnessed comprehensive multidisciplinary team (MDT) working within the A&E department. Medical and nursing handovers were not undertaken separately. This ensured that all staff working within the department were aware of individual patient needs and care was centred around this.
- There was a clear, professional and conjoined working relationship between the A&E department and other Allied Healthcare professional's within other departments. For example, Radiology. During our inspection, we observed that an emergency occurred within the Radiology department. Staff within the Radiology department remained calm and provided care for the patient while the alarm was raised with the appropriate staff within the A&E department. There was no confusion and the treatment required for the patient was clear.
- During our inspection, the trust went live onto the regional trauma network. Staff we spoke with were

aware of the protocols to follow and key contacts with external teams. We witnessed a professional patient experience transition from the care of the ambulance service to the A&E staff.

- The hospital psychiatric and alcohol team could be accessed for support and although the department did not collect data with regards to their input, the service was available when required.
- Admission avoidance through local pathways was effective, with the A&E department providing the ambulatory care service. The out-of-hours service was placed next door to the A&E department, which offered patients further care and treatment choices.

Seven-day services

- There was a consultant out-of-hour's service provided via an on-call system.
- A&E offered all services where required seven days a week.

Are accident and emergency services caring?

Good



Evidence from prior to our inspection and from speaking to patients during our inspection provided us with sufficient assurance that the A&E department at Lincoln County hospital was providing a consistently caring service. The department has worked hard to increase the NHS Friends and Family Test response rate. However, during our inspection we did find NHS Friends and Family Test questionnaires out of view behind a computer screen within the ambulance triage area. We were witness to many episodes of caring interaction during our visit. Feedback from individual patients and relatives (via interview) was universally positive.

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

Compassionate care

- We witnessed multiple episodes of patient and staff interaction, during which staff demonstrated caring, compassionate attitudes towards patients.

Accident and emergency

- The A&E department rated close to the English national average for the NHS Friends and Family Test score for Lincoln County Hospital (60). This was based upon a poor response rate to the survey.
- We looked at inpatient audits, which demonstrated to us that patients were returning to the ambulatory care service to discuss other health issues due to the good care they received on their first experience of the service.
- We spoke with staff that were knowledgeable about the care pathways available to patients and the appropriateness of each pathways benefit.

Patient understanding and involvement

- Patients told us they felt informed about their patient journey. They told us staff dealt with their needs quickly and were polite when speaking to them. We observed staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was and how long they would have to wait to be seen.
- Patients and relatives said that they would recommend the service to family and friends.
- The department arranged the nursing staff into teams that looked after specific areas, which facilitated a better patient experience by having a named nurse looking after them while in the A&E department.

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

Good



The department has recently undergone an improvement phase to cope with its routine workload, which has included extra bed space within the resuscitation area, and redesign within certain areas, including the reception area. However, the department requires improvement in coping with surges of activity, which occur on a regular and potentially anticipatory basis. Trusts in England were tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. Lincoln County Hospital was not consistently meeting this target. The trust has

struggled to maintain the 95% target, and many times has been below and above the England average. The lowest was 87.6% in April 2013. Performance has improved, but is still failing to maintain the target.

We saw during our inspection in February 2015, that the accident and emergency department coped with the surges in activity, and had clear plans in place to escalate. The department had a 12% increase in attendances over the winter period, and was consistently maintaining seeing 88% of patients within the four hour target.

The escalation protocol is insufficient and does not provide a sufficient, measurable or safe response, as evidenced by patients waiting on A&E trolleys within the ambulance triage area, while ambulances are waiting to handover. There are regular occurrences of ambulance stacking within the department, delaying the ambulance handover.

At our inspection in February 2015, we saw that the department had introduced a new role called a 'progress chaser'. This person provided a 12hr, seven days a week service, supporting and working alongside the shift co-ordinator, monitoring potential breaches, ambulance handovers, demands and activity on the department. We saw that this allowed the shift co-ordinator to have an effective clinical overview, which enhanced the timely care provided to patients. We saw that the escalation protocol was now sufficient with the integration of this model.

Service planning and delivery to meet the needs of local people

- The emergency department has a patient flow and escalation policy that was developed by the management team.
- We were told by senior staff within the department of who within the site team should be contacted when there were delays to patient flow. There was an internal 'live' electronic system of monitoring to evaluate and manage the effectiveness of patient flow and to assist with bed demand.
- During periods of demand, the department started to struggle and it was not clear who led the coordination of the teams to achieve a better patient experience and flow through the department when under pressure. We started to witness a delay in ambulance handovers and speciality reviews being delayed.

Accident and emergency

- In February 2015, we saw that the accident and emergency department experienced periods of demand. During these periods there was clear co-ordination, with the shift co-ordinator and the progress chaser working cohesively. The shift co-ordinator was identified via a red badge. When we asked the shift co-ordinator and progress chaser questions around patient flow, they were fully aware of the priorities to ensure timely patient care and referral or discharge.

Access and flow

- The trust is rated as worse than expected with regards to transition from the ambulance to the A&E department at our inspection in 2014. This is a significant contributing factor that inhibits patient flow and causes consistent ambulance handover delays. The trust had struggled to maintain the 95% target, and many times has been below the England average. The lowest was 87.6% in January 2013.
- During our inspection in February 2015, we saw that ambulances attending the department were able to hand over the care of their patients in a timely manner, and the majority within the 15 minute target. We saw that two ambulances had a slight delay to hand over their patient due to bed movement in the department. We saw that either the shift co-ordinator or progress chaser explained the reason for the delay to the patient and ambulance crew.
- The trust can be seen to be performing better than the England average for the percentage of emergency admissions via the A&E department waiting four to 12 hours from the decision to admit until being admitted. In February 2014 the trust was performing at 3% with the England average being 6%.
- The national average for the percentage of patients who leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait) is between 2 to 3% (December 2012 – November 2013). Lincoln County Hospital was at 2% in November 2013, with the highest percentage being 3% in July 2013.

Meeting people's individual needs

- We saw that the department had champions which led on specific areas to facilitate individual's needs, such as learning disabilities, mental capacity and dementia.

- There was specific equipment to provide the correct care for a bariatric service with privacy and dignity.
- In 2014, the paediatric service was co-located within the major's treatment area, and there was no specific children's waiting area. We saw during our inspection in February 2015 that there is now a specific children's waiting area.
- In 2014, we found that the area where doctors complete their clerking of patients' notes was significantly lacking in desk space and had limited computer access. Patients' A&E triage cards, awaiting the doctor's assessment, were laid out across the top of a workstation, with staff having access and completing work on top of these triage cards. This introduced an associated risk and was a procedure that had been in place for some time. At our inspection in February 2015, we saw that the department had replaced the old clerking station with a new purpose-built unit. The new unit facilitated separate stations for doctors and nurses to work with extra computer stations. Patients A&E triage cards were securely stored within a clear system that ensured confidentiality. There was no risk associated now with this area.
- We noted, in 2014, that a patient who had already been admitted, was held in the ambulance handover area due to no cubicles being available. We observed that it was difficult to maintain this patient's privacy due to ambulance crews waiting to handover another patient, and no ability to handover confidential information. The ambulance handover area was inadequate in these aspects. We observed during our inspection in February 2015 that the ambulance crews now handed over patient care to a nurse at a desk space within the new central desk unit. This enabled confidential information to be protected.

Learning from complaints and concerns

- Lincoln County Hospital reintroduced its Patient Advice and Liaison Service in 2013.
- Information was available for patients to access on how to make a complaint and how to access the Patient Advice and Liaison Service.
- All concerns raised were investigated and there was a centralised recording tool in place to identify any trends emerging.
- Learning from complaints was disseminated to the whole team in order to improve patient experience within the department.

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Are accident and emergency services well-led?

Good



Universally, throughout the department, there was an acceptance of change, and aspirations to improve. Staff believed that the departmental improvements with redesign provided an improved working environment in which to care for patients. Staff were aware of the risk highlighted in this report, such as confidentiality of records, recording of observations, and failing to meet treatment targets. These risks had been identified and action planning undertaken, but this was yet to have an impact on the safety and responsiveness of care provided. The staff we spoke with demonstrated an attitude of commitment. Morale was good.

During our inspection in February 2015, we saw that the leadership within the department had improved, and managers in the department actively engaged through shaping the culture of the department. We saw that there was regular liaison and engagement across all three accident and emergency departments within the trust.

Vision and strategy for this service

- The future vision of the department was embedded within the team and was well described by all members of staff.
- The trust had a lack of strategic vision in the promotion of the ambulatory care service, and the service was driven from within the department and not at trust-level to further avoid admissions. We saw data that demonstrated a 10% reduction in admissions to the medical emergency assessment unit, with patients being seen within the ambulatory care service. In December 2014, the trust saw an 80% admission avoidance achieved through the ambulatory care service.
- At our inspection in February 2015, we saw that the ambulatory care service was embedded within the services provided and promoted by the trust. The model enhanced the reduction in admission avoidance, which was adopted across the trust. We saw that the

ambulatory care service now had eight emergency nurse practitioners and all practitioners were nurse prescribers. The trust had sponsored six nurses to complete an academic masters (MSc) course.

Governance, risk management and quality measurement

- Monthly departmental meetings were held. We were provided with minutes of the previous meetings that had been held over the past six months.
- There was a set agenda for each of these meetings with certain standing items.
- Within the minutes, the top risks were discussed, including: what was being done to mitigate the risks. We saw little evidence that these actions were having an impact on delivering safe and responsive care.
- In February 2015, we saw that risk was assessed on a regular monthly basis, or more regularly if required. There was evidence that actions were completed, such as the increase in nurses, and training in paediatric provision.

Leadership of service

- There was a strong departmental team, who were respected and led by the senior sister and consultant nurse.
- In 2014 the senior management team were interviewed separately, and this demonstrated that the leader's visions were not aligned. At the time of the inspection there was a lack of joint ownership of the issues faced by the department.
- During our inspection in February 2015, we interviewed senior managers and saw that there was now a clear vision and clear joint ownership within the department. Individual leaders visions were aligned, working cohesively, sharing best practice across all three A&E departments.
- Regular liaison between the three A&E departments in the trust was not in place at the time of our inspection in 2014. We were informed that such liaison would be useful in imparting lessons learned from incidents and communicating good practice.
- We saw at our inspection in February 2015, that there were monthly meetings held between all three A&E departments. We spoke with all three senior managers in the departments, who confirmed the agenda and how much it had improved imparting knowledge. The

Accident and emergency

consultant nurse ensured that cross-site working took place, and nurses moved around at their request to check competency, and remain competent in areas highlighted through appraisal.

Culture within the service

- The high percentage of locum use contributed to the lack of cohesive working, with the potential to impact on the culture within the service in 2014. The vacancies within the consultant team resulted in an onerous rota, which was potentially unsustainable.
- We saw in February 2015 that the consultant rota had improved, and the department had two new consultants commencing.
- In February 2015 we saw that there was a culture of collective responsibility between all the medical and nursing teams, and the leadership now actively engages through shaping the culture of the department.

Public and staff engagement

- Information was available to all staff in different formats about the trust's vision and strategy and staff were

aware of how to access it. They were provided with updates on any changes or amendments to the department's priorities and performance against those priorities.

Innovation, improvement and sustainability

- Staff were knowledgeable on the trust's vision and journey. They were aware of the priorities for the department and the trust.
- We saw evidence of staff innovation that was put into practice and owned by the department as a team effort, including a telephone advice service provided to GPs via the ambulatory care service.
- We saw in February 2015 that the A&E department at Lincoln County Hospital had introduced improvement through innovation, and recognised the skills available within the hospital. The department has introduced operating department practitioners (ODP's) working on an ad-hoc bank system. This enhanced the skill set available within the resuscitation department supporting doctors and nurses.

Medical care (including older people's care)

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

Information about the service

The acute medical services consisted of 15 wards.

In 2014, we inspected:

- The emergency medical admissions unit (EMAU)
- Burton Ward
- Hatton Ward
- Dixon Ward
- The Cardiac short stay
- The Stroke Unit
- The Discharge Lounge

We spoke with 26 patients and relatives, and 63 staff. We observed care and treatment, and looked at care records. We received comments from the listening events, and from people who contacted us to tell us about their experiences. We held staff focus groups to gain their feedback.

In February 2015, we inspected:

- The Discharge Lounge
- Carlton/Coleby Ward
- The emergency medical admissions unit (EMAU)
- Waddington Ward
- Hatton Ward
- The Stroke Unit
- Dixon Ward
- Greetwell Ward
- The Heart Centre
- Johnson Ward

We spoke with eight patients, five relatives, and 34 staff, and looked at care records. We received comments from patients and staff prior to and after our visit.

Summary of findings

In 2014 we found that services for medical care were safe and effective because there were systems in place to identify, investigate and learn from incidents and complaints. Ward staff assessed patient risks for falls and pressure ulcers, and put in place plans of care to reduce these risks. There were processes to identify if patients were deteriorating. We found that staff were caring and compassionate, and meeting patients' individual needs. There were effective stroke and cardiac services being run according to evidence-based guidelines. We saw innovative practice on Burton Ward, which had been adapted to meet the needs of patients with dementia. The wards were well-led, and there was good communication between the executive team and staff on the wards.

We received some information of concerns about the cardiology service at the trust before we carried out our follow-up inspection in February 2015. We looked at the cardiology service being provided at the hospital. We did not identify any concerns about the service being provided at Lincoln County Hospital.

In February 2015, qualified nurse vacancies in some areas were high; there was regular use of bank and agency nurses in these areas. Medicines were being stored and administered effectively, and staff had received training on the effective use of the sepsis care bundle. Mortality rates for the trust were within expected limits, and junior medical staff felt supported and were able to access planned training sessions.

Medical care (including older people's care)

Medical outliers on surgical wards could cause a delay in treating elective surgical patients. A new 'front door frailty service' had been commenced, which had been proven to be successful. Refurbishment of two medical wards caring for older people had yet to be commenced, to reflect the needs of patients with a dementia. Lessons were being shared within the medical directorate across the trust. The executive team was more visible, although while some staff were confident about speaking out about concerning issues, others were too frightened to do so for fear of reprisals.

Are medical care services safe?

Good



We found the medical care services to be safe. Incidents were being reported and analysed and lessons learned shared with all staff. Safety Thermometer reporting in relation to new pressure sores, falls, infection rates, new venous thromboembolism (VTE) and accurate recording of risk assessments was being monitored. Clear action plans were displayed where improvements were required. Rates of C. difficile were higher than the national rates. However, the trust was monitoring this and implementing strategies for improvement.

Staffing numbers were observed to be sufficient to ensure patient safety. The cardiac wards were short of nurses. However, so active recruitment was taking place. Mandatory training and appraisals were taking place. Improvement was required in relation to medical staff knowledge of the Mental Capacity Act 2005.

We only reviewed some aspects of the service in February 2015.

Incidents

- Analysis of the National Reporting Learning System (NRLS) notifications demonstrate that the trust was reporting harmful and severe incidents appropriately.
- All the staff we spoke with were knowledgeable about the incident reporting system. Learning from incidents and complaints were shared in monthly staff meetings. Staff were able to demonstrate an example of where practice had changed as a result of incident reporting.
- All deaths were reviewed using the British Medical Journal (BMJ) proforma for mortality and morbidity meetings. Each speciality has deaths reviewed by a colleague from a different speciality and mortality figures are discussed at bi-monthly meetings.

Safety thermometer

- Analysis of the National Reporting Learning System (NRLS) notifications demonstrate that the trust was reporting harmful and severe incidents appropriately.

Medical care (including older people's care)

- All the staff we spoke with were knowledgeable about the incident reporting system. Learning from incidents and complaints were shared in monthly staff meetings. Staff were able to demonstrate an example of where practice had changed as a result of incident reporting.
- All deaths were reviewed using the British Medical Journal (BMJ) proforma for mortality and morbidity meetings. Each speciality has deaths reviewed by a colleague from a different speciality and mortality figures are discussed at bi-monthly meetings.

Cleanliness, infection control and hygiene

- C. difficile infection rates were above the trust's projected trajectory. This was being monitored by the infection prevention and control team. Action plans are updated weekly and added to the trust intranet site to ensure all staff are aware of targets and current performance. New incidences of both C. difficile and MRSA bacteraemia were displayed on each ward.
- Statistical analysis of C. difficile infection data over the period November 2012 to October 2013 showed that the number of infections reported by the trust was higher than statistically acceptable when compared to other trusts of similar sizes. The past few months demonstrated a downward trajectory.
- The trust number of MRSA bacteraemia infections attributable to the trust was within a statistically acceptable range relative to the trust's size and national level of infections, hence there was no evidence of risk.
- Ward areas looked clean and we saw staff regularly wash their hands and use hand gel between patients. Bare below the elbow policies were adhered to. We observed beds being cleaned between each patient.
- There was segregation of clinical, domestic and cytotoxic waste. Sharps bins were being used appropriately.

Environment and equipment

- The environment on the medical wards was safe.
- Equipment was appropriately checked and cleaned regularly.
- Resuscitation equipment was checked daily and documented. Monthly audits were carried out to ensure these checks were being completed on each ward.

Medicines

- **When we inspected the hospital in February 2015, we took a pharmacist with us to look in detail at the processes in place.**

- 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.
- Staff administering drugs wore a burgundy tabard to alert other staff, allowing them to avoid unnecessary interruptions.
- We looked at prescription and medicine administration records for seven patients on two wards. We saw appropriate arrangements were in place for recording the administration of medicines. The records were clear and fully completed. They 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 patients 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. 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 used for ward stock, and other medicines were ordered on an individual basis. Therefore, most patients had access to medicines when they needed them.
- A pharmacist visited all wards daily. Pharmacy staff checked that the medicines patients were taking when they were admitted were correct, and records were up to date. However, staff vacancies in the pharmacy at the hospital limited the service provided to the wards. We saw that a very small number of patients had missed some doses of some of their medicines, as prescription charts were in the pharmacy and not on the ward. The site lead pharmacy manager and the trust chief pharmacist 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.
- In the discharge lounge, one patient had been prescribed two medicines for reducing their cholesterol

Medical care (including older people's care)

level. The patient had been admitted on one of those medicines which had been reduced by half during their admission. On discharge, the patient had been written up for that drug plus another medicine which had the same effect. Nursing staff in the discharge lounge had noticed this, and were taking actions to clarify what the prescription should be before the patient went home.

Records

- All records were in paper format and all healthcare professionals documented in the same place.
- Monthly documentation audits were carried out to ensure risk assessments were being completed. This information was displayed on each ward. The ward managers were aware of areas requiring improvement and action plans addressing deficits were also displayed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff we spoke with had a good understanding of their role in relation to the Mental Capacity Act 2005.
- The safeguarding lead informed us that a patient with learning disabilities had not had their capacity assessed. This incident had been identified and reported and no harm resulted.

Safeguarding

- Staff we spoke with were aware of the safeguarding procedures within the trust.
- The safeguarding lead had audited the safeguarding process and found that it required shortening. It could take up to five days to process a safeguarding report.
- During our visit in February 2015, the emergency medical admissions unit (EMAU) had arranged their own safeguarding training to ensure that all band 6 nurses were trained to level 2.

Mandatory training

- The trust has implemented a new mandatory training framework.
- Staff we spoke with said they were given dedicated time to attend training.
- Mandatory training records demonstrated that, in the majority of wards, staff were receiving their training. Ward managers were aware of where they were not meeting their training and appraisal rates and were actively working to improve them.

Management of deteriorating patients

- The medical wards used a recognised early warning tool. There were clear directions for escalation on the observation charts, and we saw that these had been followed appropriately. In February 2015, training had been rolled out to all staff to ensure they understood how to utilise the sepsis care bundle appropriately. We saw this in use on the wards we visited.

Nursing staffing

- Nursing numbers were assessed using a template based on national levels. Ideal and actual staffing numbers were displayed on every ward. Most of the medical wards were now fully staffed with the exception of the cardiac short stay ward. This was recognised and the trust was actively trying to recruit. National cardiology staffing guidelines recommend one qualified nurse to five patients. Staff told us that sometimes they were responsible for seven to nine patients.
- Matrons assessed skills mix and levels of staffing in relation to patient dependency. There was a systematic process for reporting staffing requirements to the director of nursing and director of operations and the internal nurse bank.
- There were daily multidisciplinary ward meetings where each patient was discussed on most of the medical wards. The stroke unit had a weekly multidisciplinary meeting to discuss all patients. All the wards had daily nurse and consultant rounds where each patient's plan was discussed and actions to be completed updated on a board. Discharge planning commenced on admission and was discussed daily.
- Staffing shortages were mainly filled with nurses from the internal bank.
- During our visit in February 2015, we found that some of the medical wards we visited were struggling to maintain their agreed staffing levels. We had also been informed about this prior to our inspection.
- On the emergency medical admissions unit (EMAU) two or three agency nurses were used most nights to maintain safe staffing levels. However, the agency staff were used to the unit as they undertook regular shifts there, and they had undertaken an induction to the unit. EMAU had seven band 5 nurse vacancies, and three more had handed in their notice. Another six qualified staff were on maternity leave. We were informed the unit was constantly attempting to recruit staff.

Medical care (including older people's care)

- Prior to our inspection in February 2015, we had been alerted to the fact that some members of nursing staff had serious concerns relating to the shift systems that had been introduced by the trust 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 times a week. Some of those staff had informed us that those shifts made them extremely tired; this was also evidenced when we spoke to staff during our visit. We received information from members of staff that this had led to wards losing nurses as a result. The trust informed us that the system would be reviewed in April 2015.

Medical staffing

- There was consultant presence on all medical wards seven days a week during daylight hours.
- The only medical unit which consistently had middle or senior-grade registrars was the gastro-intestinal unit.
- The consultants were well trained but a number were long-term locums. In February 2015, we were informed that two care of the elderly consultants were due to be appointed by the trust.

Major incident awareness and training

- Within the operations centre, the site duty manager and bed manager constantly assessed A&E flow and discharges. Regular bed meetings were held to present actual and potential availability. Opening of extra beds was planned early in the day to provide time to get agency and bank cover. Skills mix is assessed and experienced staff were used to cover extra beds.
- We had been informed of the acute pressures that the hospital had been under since Christmas 2014, because of high levels of patient activity. The trust had worked with the community trust and other agencies on a daily basis to ensure patients were cared for as promptly and safely as possible in the most appropriate setting. During our inspection in February 2015, we found the pressure on beds had begun to reduce.

Are medical care services effective?

Good



Treatment was evidence-based and the trust was meeting national targets in relation to stroke and cardiac

management. There was good multidisciplinary working, and services were provided seven days a week, apart from the pharmacy. Staff were well-trained and were receiving their appraisals to monitor their competence.

In February 2015, the summary hospital-level mortality indicator (SHMI) and the hospital standardised mortality ratio (HSMR) for the trust were within the expected limits. Junior medical staff felt support from senior colleagues was good, and they were able to access planned training sessions. Psychiatric services were available within 24 hrs once a patient was medically fit, although additional staff were not always available to support those patients as an interim measure.

Evidence-based care and treatment

- The medical department used a combination of NICE and royal college guidelines to determine the treatment they provided.
- New clinical guidelines were discussed at clinical governance meetings and assigned to the relevant speciality for implementation.
- The clinical audit data that was presented was evidence-based and demonstrated achievement to national guidelines.

Pain relief

- Nursing staff had received specific training on pain relief for older people from the clinical nurse specialists.

Nutrition and hydration

- There were protected meal times in place on the medical wards. We observed staff helping people to eat in a sensitive and caring manner.
- Nutritional risk assessments were being used on all the medical wards and we found that these were being completed.
- We spoke with a relative on Hatton Ward during our visit in February 2015, who told us of their concern about their relative's care when they had been admitted two months earlier to the same ward. Their concerns were around lack of hydration. Fluids had been given to the patient overnight and the situation had been resolved. They had not encountered any problems on their relative's current admission.
- On Waddington Ward staff had enabled a patient to bring a sandwich toaster onto the ward to encourage them to eat. The patient had started to increase their weight as a result of this.

Medical care (including older people's care)

Patient outcomes

- At the time of the Keogh Review the trust was flagged in respect of mortality outliers for previous years. However, at the time of this report the trust SHMI and HMSR data is within expected limits.
- The trust also had a mortality outlier for septicemia, which the trust were preparing a response for at the time of the 2014 report. However in 2015 this issue had been resolved. Posters were displayed showing the sepsis pathway to ensure staff were clear of the current guidelines.
- The trust reviewed the information they held for the septicemia mortality outlier and put actions in place to reduce risks to patients. As a result, the outlier was considered closed in January 2015. At the time of this report, the summary hospital-level mortality indicator (SHMI) and hospital standardised mortality ratio (HSMR) were within the expected limits.
- According to the trust's quality account, they participated in 86.8% of possible national clinical audits and 100% of the national confidential enquiries in which they were eligible.
- Performance in the Sentinel Stroke National Audit (SSNAP): The Stroke Unit were measuring themselves against more parameters than the national SSNAP audit required. They were meeting, and in some cases exceeding, the nationally-agreed best practice standards.
- Performance in the Myocardial Ischemia National Audit Project (MINAP): The cardiac unit was achieving above average for the national targets.
- Readmission rates compared favourably with national comparators.
- Outcomes for patients undergoing primary percutaneous coronary intervention (pPCI) were good. Eligible patients who received pPCI within 150 minutes of calling for help and getting the procedure was 86%, the England average was 82.1%. The number of patients who received pPCI within 90 minutes of arrival at the Heart Centre was 99%, which was significantly better than the England average of 92%. This was due in part to an exceptionally well designed Heart Centre that was adequately staffed to ensure patients received a rapid service.

Competent staff

- Nursing staff appraisals were up to date in most of the medical wards. The managers were aware of any shortfalls and were addressing this. There was a new values-based approach to appraisals, which was well received from staff we spoke with.
- Medical staff mandatory training was up to date. One senior house officer (second year doctor) we spoke with felt there was too little bedside teaching, which was insufficient for her portfolio.
- In February 2015, all junior medical staff we spoke with informed us that they received good training and support from their consultants, which included training on daily ward rounds. They had been able to attend planned teaching sessions.
- Data from the GMC showed that 66 of 70 doctors had been revalidated since 2012.

Multidisciplinary working

- There was evidence of good multidisciplinary team working. Occupational therapists, speech therapists and physiotherapists were all based on the stroke unit. Therapists were available seven days a week apart from speech therapists.
- Nurses had support from tissue viability, dementia and other specialist nurses.
- The clinical director for medicine and an occupational therapist we spoke with said there was poor access to psychiatric services for patients. This service is provided by the local mental health trust.
- In February 2015, we found access to psychiatric services in the emergency medical admissions unit sometimes proved problematic, as patients could only gain access to the psychiatric crisis team - which was not based in the hospital - when they had been deemed medically fit, such as after they had recovered physically from taking an overdose. This could take up to 24 hours. As a result, if patients were distressed or agitated, more staff were required to care for them; this was not always available. Two medical staff we spoke with told us there could be delays in obtaining specialist psychiatric care for some patients.
- We saw there was excellent working as part of a multidisciplinary team within the cardiology service at the hospital. Nurses, allied healthcare professionals and medical staff worked together to ensure the best care for patients was delivered.

Medical care (including older people's care)

Seven-day services

- There was consultant presence seven days a week on the medical wards. On the emergency medical admissions unit there was a ward round twice a day at 8am and 5pm and a 'board' round at lunchtime where each patient's plan was discussed.
- Radiology services were also available seven days a week.

Are medical care services caring?

Good



Medical care services were found to be caring. We observed compassionate, respectful care and patients being treated with dignity. Patients and relatives gave very positive feedback about the staff. Both patients and relatives felt well supported and informed about the care received.

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

Compassionate care

- Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment, the results have been used to formulate the NHS Friends and Family Test results.
- The trust scored below the England average from November 2013 to January 2014, with the exception of October 2013 when they scored 72; above the England average of 69. However, the medical wards we visited were achieving good NHS Friends and Family Test results for March 2014.
- Analysis of data from the CQC's Adult Inpatient Survey 2013 showed the trust was performing "the same as other trusts" for nine of the ten areas of questioning.
- The trust was performing worse than other trusts nationally for 28 of 69 questions asked in the 2012/13 Cancer Patient Experience Survey.

Patient understanding and involvement

- Patients were aware of who their nurse was. Nurses were allocated to patients to ensure continuity of care from day to day.
- Patients on all of the medical wards we visited spoke very highly of the staff. Patients felt involved in their care and said staff explained their treatment clearly.

Emotional support

- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. There was a calm atmosphere on the medical wards. One patient said, "They've been wonderful, they've cherished me."
- We observed ward rounds and saw that staff introduced themselves. Curtains were drawn to maintain patient dignity.
- Staff were observed assisting patients to eat their meals in a calm and sensitive manner.
- Relatives we spoke with felt supported and were kept informed.
- There was a relative's room on the wards where sensitive conversations could take place.
- Clinical nurse specialists were available to provide additional support to patients and ward staff.

Are medical care services responsive?

Good



Medical care services were found to be responsive to patients' individual needs. Discharge planning, although commenced as soon as the patient was admitted, often failed to meet the plan, with delays of hours and days frequently experienced by patients. There were examples of innovative practice to meet the needs of patients with dementia. One ward had been refurbished to make an environment conducive to caring for patients with dementia. Themes from complaints were analysed and lessons learned shared with staff to improve practice.

In February 2015, medical outliers on surgical wards could cause a delay in treating elective surgical patients. Because of the lack of community facilities for older people, this sometimes delayed discharge. A new 'front door frailty service' had been commenced, which had proved successful in discharging patients more swiftly and reducing the number of days spent in hospital. Apart from one ward, refurbishment of medical wards caring for older people had yet to be commenced to specifically cater for the needs of patients living with dementia.

Service planning and delivery to meet the needs of local people

- There were regular bed meetings where the site duty manager and bed managers constantly assess the flow of patients into A&E and discharges.

Medical care (including older people's care)

- Staff we spoke with said improvement was required to allow access to psychological support for patients.

Access and flow

- Patients were admitted to the emergency medical assessment unit direct from A&E or from their GP.
- The trust was rated as 'low risk' for access to secondary care through A&E. It was rated 'high risk' for access to elective secondary care (diagnostics and treatment) from general practice.
- Daily board rounds were undertaken seven days a week, where discharge plans were discussed. Discharge planning commenced as soon as patients were admitted to the ward.
- There was a delay in discharge of 48 to 72 hours, due to the slow response of the social care services. Although there were nominated social workers for wards, they were not present on the consultant-led ward rounds at 8:30am. The social workers were employed by the Council. There were no social workers present during our visits to the medical wards for us to speak with.
- Patients would not be seen by a social worker until they were deemed "fit for discharge."
- On the day we visited Lincoln County Hospital in February 2015, there were 25 medical outliers in the hospital. Medical outliers are patients who are cared for on wards that do not specialise in medicine. The most on any one ward was nine on a ward that specialised in general surgery. Medical outlier levels were generally between 10 and 30 each day, but could rise to 45 during really busy periods.
- All medical outliers were clearly identified as such on each ward's 'white' board in red, with the name of the responsible consultant. The daily management of the patients was undertaken by the junior medical staff responsible for the ward; we were informed by medical staff that the consultant visited frequently to check on progress and manage their care effectively.
- If medical outliers were cared for on surgical wards there was a negative effect on the number of available surgical beds for elective surgical procedures.
- During our visit in February 2015, we were informed by medical staff that there were frequent delays in discharging patients because of the lack of rehabilitation facilities and beds in the community.
- We spoke with the consultant responsible for setting up a 'front door frailty service' for the elderly. The service is designed to assess elderly patients in the emergency

department. The team consists of consultants and specialist nurses. An assessment from an occupational therapist and a physiotherapist is available. The team can discharge patients home, or admit directly to one of the three care of the elderly wards in the hospital. Analysis of outcomes for the service shows the scheme had reduced the length of stay for patients by four days. Of frail elderly patients, 30% were discharged in less than 24 hours.

- Analysis of the ratio of the total number of delays in transfer from hospital to the total number of occupied beds (January 2013 to March 2013) showed no evidence of risk.
- Electronic discharge letters were sent direct to patients' GPs. These detailed the reason for admission and any investigation results and treatment received.
- Within the Adult Inpatient Survey 2013, there are two questions related to the process of discharge. For both questions about delayed discharges, the trust scored similar to expected (in comparison to other trusts).
- There was a discharge lounge, which had a structured approach to manage discharges and improve patient flow throughout the hospital.
- Each medical ward was 'buddied' with a surgical ward for medical outliers. There was a medical outlier policy, which ensured that palliative care and patients with dementia or confusion were not transferred to another ward. Daily discussions took place between consultants and nursing staff regarding moving patients to non-medical wards. All outliers were seen by their own consultant on a daily basis.
- There was a policy regarding bed moves, which had been shared with all the ward managers and staff. This contained time restrictions to ensure patients were not transferred to other wards after 10pm.

Meeting people's individual needs

- Staff on the medical wards had competency-based training on caring for patients with complex needs. This training was provided by the clinical nurse specialists.
- There was good access to translators and a language line to assist staff with communicating with patients whose first language was not English.
- Support was available for patients with dementia and learning disabilities. Each ward had a dementia champion whose role was to educate ward staff. There was also a clinical nurse specialist for learning disabilities, to support staff and patients.

Medical care (including older people's care)

- One medical ward (Burton) had been refurbished and adapted specifically for the needs of patients with dementia. There were plans in place to ensure all of the medical wards for older people were adapted to the same high standards. We saw this as an example of good practice.
- On our visit in February 2015, we found that the refurbishment of other medical wards caring for older people had yet to be commenced to specifically cater for the needs of patients living with dementia.

Learning from complaints and concerns

- Complaints were dealt with in line with the trust policy. If a patient wanted to make an informal complaint, they could discuss it with the nurse in charge for that shift. If the nurse could not deal with their concerns, they would be directed to the Patient Advice and Liaison Service. If patients still had concerns, they would be advised to make a formal written complaint. This process was outlined in leaflets throughout the medical wards.
- Themes from complaints were discussed at governance meetings and then discussed at weekly staff meetings. Notes from these meetings were available for all staff within their communication folders. Staff had to sign to say they had read them.

Are medical care services well-led?

Good



Medical care services were found require improvement in this domain. Despite evidence of good communication between the senior executive team and staff on the wards, this was not replicated across the three acute hospital sites, where good practice was not shared across the directorate. Staff at all levels were aware of the trust's objectives and targets. There was a positive culture, with passionate staff eager to drive improvement, and put quality and safety at the centre of patient care. Staff felt well-supported within the management structures. There were effective governance systems in place to drive improvement.

In February 2015, lessons were being shared within the medical directorate across the trust, although lack of staff had sometimes prevented staff from attending meetings.

The executive team within the trust was more visible. Some staff we spoke with were confident about speaking out about concerning issues; other staff were too frightened to do so for fear of reprisals.

Vision and strategy for this service

- The vision and strategy was displayed on ward notice boards.
- Staff spoke passionately about the trust's aims and objectives on an individual basis and at focus groups.
- There was a trust-wide cardiology strategy in place. Staff working at the hospital were aware of the vision and strategy for the cardiology service.

Governance, risk management and quality measurement

- Quarterly governance meetings were held. Information from these meetings was then passed on to staff via weekly ward meetings.
- Incidents, complaints, Safety Thermometer results, C. difficile and MRSA figures, mortality outliers, cardiac and stroke targets and patient feedback were discussed. Results were benchmarked against national data.
- Staff on the wards were aware of the targets and where improvement was required.
- Good practice at other sites was not shared across the trust. An example of this is the positive outcomes of the stroke pathway at Pilgrim Hospital, Boston.
- In February 2015, we found lessons were being shared across the trust, although this had sometimes been difficult because of the pressure all the hospitals had been under, and as a consequence, the lack of availability of staff to attend meetings. Staff had found this frustrating.
- A senior member of nursing staff told us that they encouraged their band 7 nurses to attend the three hospital away-days (Lincoln, Pilgrim and Grantham), as they felt they were very useful, and each site could exchange ideas and good practice.

Leadership of service

- There was a clear leadership structure. Matrons were visible and provided support to the ward managers. The exception to this was on the discharge lounge where staff did not regularly see the matron.
- Staff spoke positively about the chief executive officer (CEO), and gave an example of where the CEO had been invited to discuss an issue and had resolved the issue promptly.

Medical care (including older people's care)

- Staff felt involved in the 'listening events' where they were encouraged to highlight areas for improvement and possible solutions.
- In February 2015, staff told us about the higher visibility of the acting chief nurse. They told us she was easy to talk with and listened to what they said.
- A consultant we spoke with during our visit told us they had always had a good relationship with the executive team at the trust and it was now much more visible. This had included the chief executive officer, acting chief nurse and the medical director.
- Prior to our visit in February 2015, we had been contacted by members of staff, who had told us that on some of the wards in the hospital there was still a worry about speaking up for fear of reprisals. We spoke to staff about this when we visited the medical wards. The responses were variable, with some confident about speaking out. Others stated they were too frightened to do so.
- There was good team working throughout the cardiology service, 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.

Culture within the service

- Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility. Nursing and Allied Healthcare professionals felt there was an open culture where they could report incidents and concerns.
- The consultants were observed to be apathetic and shell-shocked following the adverse publicity arising from the previous reviews of the hospital.
- There was a general culture of fear of whistleblowing.
- There was good multidisciplinary working and respect amongst staff.
- Staff spoke of an improved culture. One nurse said, "I feel happy to come to work."







Public and staff engagement

- The NHS staff survey results for 2013 demonstrated that the trust was performing worse than expected or tending towards worse than expected for 27 of 28 key findings. However, in a recent "pulse check" the trust demonstrated that staff felt that there had been recent improvements.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff across disciplines. Staff discussed quality improvement projects they had been involved with and gave examples of how practice had improved as a result.

Surgery

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

Information about the service

The surgery division at Lincoln Hospital provided 188 surgery inpatient beds across four surgery wards and two orthopaedic wards. The hospital had a surgical admissions lounge and day surgical unit. There were 11 operating theatres within surgery (not including maternity) and a 12 bed post-operative recovery room with a separate two-bed recovery for children. The paediatric recovery area was also used as a high dependency area for children prior to their transfer to another hospital. The area was supported by anaesthetics and paediatrics staff. The hospital provided a range of surgery including trauma, orthopaedic, ophthalmic, urology, ear nose and throat (ENT), maxillofacial, gynaecology, colorectal and general surgery. The main operating department had nine theatres, of which one or two are used for emergency admissions and the other eight for elective procedures. The day surgery operating theatre had two theatres, which are used for day surgery only. There is a theatre team on-site at all times and another that can be called into the hospital should it be required.

In 2014, we visited six surgery wards, including the trauma and orthopaedic (T&O) wards, the surgical emergency admissions unit (SEAU), the surgical admissions lounge, the day surgery unit and the operating theatres. We talked with 16 patients, four relatives and 32 staff, including nurses, healthcare assistants, operating department practitioners, doctors, consultants, support staff and senior managers. We were supported by two specialist advisers during this inspection, both of whom had clinical knowledge of surgery services. We observed care and treatment, and

examined the records of 26 patients. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

In 2015, we visited four surgery wards and the SEAU. We talked with six patients, one relative and 24 members of staff. We were supported by one specialist advisor during this inspection. We also observed care and treatment, and examined the records of 12 people using this service. We carried out a focused inspection of the oromaxillofacial service (OMFS) because of information received and concerns which had been raised in relation to the service. We spoke with a total of 17 staff from the OMFS service, this included administrative, nursing, junior and senior surgical staff and senior members of trust management involved in the service.

Surgery

Summary of findings

In 2014 we found that care provided was not always safe and did not always meet the needs of the patient, particularly when it came to bowel care. We identified multiple medication errors at prescribing and administration stage. These were not consistently reported, so that staff could learn and actions could be taken to reduce the risk of reoccurrence. The management team for the surgery service assured us that they would implement immediate improvements in these areas, and maintained that they had clinically reviewed all patients identified at risk of bowel concerns. They also told us that they had conducted additional medication audits during our inspection to resolve concerns. These concerns were reviewed on our unannounced visit. In 2015 we reviewed these areas again and noted continued improvements.

Services were provided in a clean and hygienic environment, in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections. In the majority of wards we saw staff that were caring. The patients we spoke with complimented staff on their caring approach and professionalism. However, we identified that staff on Stow Ward were not always caring, did not always respond to patient's needs, and did not always treat patients with dignity or respect. We discussed this with senior managers, who put systems in place to ensure patients' needs could be met. When we returned on our unannounced visit, we found that these had remained in place and patients reported good care on this ward. In 2015, Stow Ward was no longer in use. This ward had been closed and a new ward, Shuttleworth, had been opened. We saw significant improvements had been made in culture, staff attitudes and the caring nature of the ward.

Gaps in staffing were met using bank (overtime) and agency staff, but such staff were not always available. The trust has a recruitment programme; however, staffing levels within the surgery areas were low at the time of our inspection based on the level of acuity seen in the wards. The management team of the surgery service assured us that they would provide additional staff where patient acuity changed, but they had some

difficulties ensuring that bank or agency staff turned up. In 2015, recruitment and retention was still a challenge for the surgery division and for the trust as a whole. We found that this was, however, being managed effectively, and recruitment drives and initiatives were still regularly taking place. A recent uplift in staffing had also been agreed.

Our findings in 2015 demonstrated that the surgery division at this hospital had worked extremely hard in making positive changes to improve the service provided to its patients. Ratings improved in four out of the five areas. However, improvements are still required, and these relate to infection control procedures, maintaining a safe environment, medicines management, application and understanding of the Mental Capacity Act, and capacity and demand on the service.

Surgery

Are surgery services safe?

Requires improvement



In 2014 through examination of peoples' records, we identified issues multiple medication errors at prescribing and administration stage. For example, we identified one patient who had been prescribed ten times the recommended dose of a medication that could have caused harm. Incidents such as these were not consistently reported by staff; this meant that the trust could not learn and put systems in place to prevent mistakes from occurring. In 2015, we found that there had been improvements in medication incident reporting, and staff were clear about lessons learnt and were able to articulate these to us during our inspection. Increased auditing was in place, and medication errors were monitored through the safety dashboard. The oromaxillofacial service (OMFS) did not provide full assurance that learning from incidents had been undertaken or implemented throughout the service. The Surgical Mortality and Morbidity Meeting included OMFS, however the OMFS consultants attendance at these meetings was infrequent.

In 2014, bowel care had not been monitored effectively across the surgical service. For example, we identified one patient who had not had a bowel movement for nine days. We found that the risk to the patient had not been identified by nursing or medical staff, which could have placed the patient's health at risk. The management team for the surgery service assured us that they would implement immediate improvements in these areas. They said that they had clinically reviewed all patients identified at risk of bowel concerns, and they conducted medication audits during our inspection. In 2015, we reviewed the records of 12 people using this service. These were generally well completed and up to date.

Incidents

- Prior to this inspection, we were aware that there had not been a 'never event' at Lincoln County Hospital within the last 12 months. However, staff were aware of the previous 'never event', and documentation showed that this was discussed at meetings.
- During the inspection in 2014, we observed an incident that had occurred, and observed staff work collaboratively in completing an incident form. Senior staff were clear about actions to be taken and what learning outcomes were to be implemented as a result of the incident.
- Learning from incidents was cascaded down following local governance meetings, with key learning displayed on each ward or department noticeboard. In 2015 we found that this continued to occur in all but the OMFS service where we found that following a never event in 2012 policies and procedures had not been updated and staff were not aware of initiatives to reduce the likelihood of a reoccurrence.
- The service held regular monthly mortality and morbidity meetings, which are chaired by the clinical director and senior nurse for the services. We saw minutes of this meeting, and actions and outcomes displayed on ward boards. Ward sisters monitored the actions taken to reduce mortality. However in 2015 we did not find evidence that the OMFS service participated in regular Mortality and Morbidity meetings held at divisional level. The service did not provide any documented meeting minutes or evidence of OMFS representation at divisional Mortality and Morbidity meetings. There has been no OMF deaths in the past year and the Trust told us any that occur would be reviewed as part of the surgical governance meetings.
- In 2014 medicines errors across the surgery service were significantly under-reported. A pharmacist stated, "we would do nothing else if we reported every error we saw". This meant that the reporting of medicines errors was not being undertaken in accordance with the trust's incident policy. This also meant that patients were at risk from medicines errors because lessons to be learned had not been identified. In 2015, staff we spoke with were clear about their responsibilities in reporting medication incidents. We saw that work had been undertaken to include increased monitoring and auditing, and trend data demonstrated continued improvement. When asked, staff were confident in talking about recent medication incidents, and how they had learnt from these.
- There were systems in place that ensured reported incidents were reviewed to learn from mistakes and improve safety standards. Those that were not reported were not being captured and therefore learning could not occur.

Surgery

Safety thermometer

- In 2014 the hospital performed worse than the national average for catheter or urinary tract infection (UTI), and for the number of patients with falls with harm, though this data included some falls prior to admission.
- The number of patients with new pressure ulcers fluctuated above and below the national average.
- The number of patients with new venous thromboembolism (VTE – blood clot in the veins) had been consistently worse than the national average up to November 2013, when improvements were noted. It is notable that the trust has continued to improve on VTE compliance.
- In 2015 we found that no safety thermometer data was displayed within the OMFS areas.

Cleanliness, infection control and hygiene

- Measures were in place to ensure patients were protected from the risk of infection.
- The trust's infection control rates for MRSA were within expected ranges.
- Statistical analysis of C. difficile infection data over the period February 2013 to January 2014 showed that the number of infections reported by the trust was higher than statistically acceptable. While this was noted, we saw an improvement in the overall infection rates for C. difficile across the surgery service.
- There were infection control link staff members for each area. We saw evidence of regular audits in areas we visited, with the results and action points clearly displayed on the notice boards.
- The trust took action where it found higher than expected numbers of infections. This is evidenced by the move from Clayton Ward (formerly Shuttleworth) to an environment that was more easily cleaned. There was a reduction in infections following the move.
- Health Protection Agency data for surgical site infections showed that practices of reducing infections on surgical sites had improved, with Lincoln County Hospital performing within the expected ranges. We found that the hospital had a relatively low incidence of orthopaedic surgical site infections. The fractured neck of femur infection rate for Lincoln County Hospital during 2013 was 18.5%, which is below the England average of 19.2%.

- All elective patients who attended the preoperative assessment area before their operation, other than those undergoing an ophthalmic procedure or endoscopy, were screened for MRSA.
- Each ward we visited had dedicated domestic staff who were responsible for ensuring the environment was clean and tidy. Patients we spoke with were complimentary about the cleanliness of the hospital and we did not receive any negative comments about cleanliness.
- Appropriate measures were in place to prevent the spread of infection through appropriate hand cleaning and PPE availability. However, in 2014 we observed a number of doctors during our inspection who did not adhere to the trust's infection control policy, because they were not 'bare below the elbows'. We observed several doctors with sleeves only partially rolled up. Whilst improvements were observed in 2015, we saw on a number of occasions staff not washing their hands between patient contacts, and one member of staff not changing their PPE between seeing patients.
- We saw that there were appropriate systems in place for the cleaning and decontaminating of equipment.
- Isolation procedures were seen to be observed. However in 2015 we did not see any evidence that these were in place within the OMFS areas, but no patients required isolation during the inspection.
- In 2014 we saw that one patient admitted, complaining of vomiting and diarrhoea, was placed in an open bay. Further testing of this condition had not been undertaken, which meant that patients on Stow were placed at risk of infection because the risk of spreading infection had not been identified or managed on admission. In 2015, we observed appropriate isolation of infectious patients.

Environment and equipment

- All the equipment we saw had been checked and was signed as safe to use. We saw the checklists in the operating theatre that were undertaken prior to an operating list commencing, such as those relating to the anaesthetic equipment and specific equipment required to carry out the operation.
- Equipment required for resuscitation was checked and a checklist completed on a daily basis.
- In 2014 we found that all surgical wards had limited storage capacity, which meant that deliveries and some equipment was stored in corridors or bathrooms. This

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had not improved in 2015. We observed ill-fitting curtains and equipment such as wheelchairs, empty food trolleys and laundry baskets taking up space in corridors and outside bays.

- Neustadt Welton was a recently refurbished ward in 2014. The ward layout and design meant that people were visible at all times and that there was a sufficient amount of space between each bed. We spoke with three patients on the ward who were very complimentary about the environment on Neustadt Welton. One patient told us, "It is very nice in here."

Medicines

- Medicines, including controlled drugs, were safely and securely stored in all wards and departments we inspected. 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.
- In 2014 we identified medicines errors on Stow, Digby, Greetwell and Clayton Wards. In one example, we found that a drug had been prescribed to a patient at ten times the recommended dose. This was, however, identified by pharmacy as part of the routine checking carried out and therefore not administered. In a second example, we found that medicine was written on a patient's medicines chart to be 'crushed and mixed with water' when it should have been taken orally. While staff assured us that this was taken orally, the recorded evidence did not support this. We were therefore not assured whether or not that the medicine was being given covertly. Overall, we were concerned about the management of medicines on those surgery ward areas.
- In 2015, medication records we reviewed were up to date and accurate. A pharmacy inspector was also present on this inspection, and visited Shuttleworth and Greetwell Wards, and found that 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 eleven patients on the two wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed.
- However, we found that on one ward medication fridge temperatures were not being maintained. This meant that medications were not being stored safely.

Records

- We reviewed 26 patient records across six wards, the day surgery unit and in the operating theatre. We noted that appropriate assessments had been completed accurately, such as venous thromboembolism (VTE) risk assessments, pressure ulcer risk assessments. Despite a system of auditing, we identified gaps throughout the records. For example, a VTE assessment had not been in date, bowel monitoring was not being recorded consistently across various documentation, blood sugar monitoring charts had not been completed accurately. This meant that we were not assured that the records were always completed accurately or were fit for purpose.
- We observed good use of the World Health Organization (WHO) surgical safety checklist. We reviewed 11 sets of records and found that in the majority of records the WHO was well completed and matched what we observed during our time in theatres. An audit was completed on a monthly basis, to ensure that the completion of the WHO was being adhered to. The results were shared with staff at their local department meetings and during governance meetings. We noted that the undertaking of the WHO was still in its infancy and was still being embedded as a procedure, but the completion of the checklists was being done appropriately.
- On most wards, patients' nursing records were kept at the bedside. Medical notes were stored securely in lockable trolleys. However, notes were often loose and fell out of the folders as we picked them up. Therefore, we were not assured that the specific records required for a person's care were kept securely and could potentially breach their confidentiality should the documents be misplaced or misfiled.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training on consent, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was

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provided to staff. In 2014 not all staff had received up-to-date training in these subjects. We observed that the mandatory training figures for the trust overall in November 2013 was at 54%. In 2015, we asked to review up to date training figures and found that whilst figures had improved these were still not in line with the targets set by the trust.

- However, during our 2015 inspection, there was inconsistent understanding from staff that we spoke to with regards to MCA and DoLS. For example, one staff member talked about the Mental Health Act, and another had not received training, so could not answer our questions.
- Consent forms had been completed and signed appropriately. We also observed that in theatre the consent was rechecked prior to the patient being anaesthetised.
- Staff had the appropriate skills, training and knowledge to obtain consent from patients or their representatives. We looked at records for 26 people and found that in the majority of cases, both verbal and written consent had been obtained from patients, and that planned care was delivered with their agreement.

Safeguarding

- Nursing staff had a good understanding and awareness of the trust's safeguarding systems and processes, and how they would report any concerns. This information was then shared with the rest of the staff on the particular ward. However, there were three junior medical staff who were not clear what process to follow should they have a safeguarding concern.
- In 2015 we found that four safeguarding investigations were on going by the local authority safeguarding team at the time of our focused inspection of the trust's Oral and Maxillofacial Surgery service.

Mandatory training

- In 2014, some areas of surgery had higher levels of compliance than others. Staff stated that attendance was dependent on staffing levels. This meant that we were not assured that there were suitably skilled or trained staff on duty at all times to meet people's needs across surgery, because mandatory training levels fluctuated between departments. In 2015, we found that improvements had been made, and on average, mandatory training figures were at 71% across the trust. However, work is still required to ensure that suitably skilled and trained staff are on the wards at all times.

- To reduce moving and handling incidents, the trust had invested in new equipment and training for staff. However, training records displayed on notice boards in ward areas showed that many staff had not received this training. For example, on SEAU only two of the 18 healthcare support workers had received this training. We observed staff incorrectly moving patients in theatres. Having put a patient slide board (PAT slide) and a slide sheet in place, the staff proceeded to lift the patient across and did not slide them.

Management of deteriorating patients

- In 2014, 'track and trigger' enabled staff to monitor key areas of deterioration closely, and escalate more detailed concerns sooner. This process was introduced some years ago and it was working well throughout surgery at the time of our inspection. NEWS (national early warning score) is being implemented from 1 July 2014. During our inspection in 2015, we found that NEWS was well embedded and documentation reviewed confirmed it was being used effectively.
- There was an outreach team (linked to the critical care team) who were able to provide expert advice and guidance to support the ward in the effective care management of patients whose conditions had deteriorated.
- Patients who presented with OMFS concerns at Pilgrim Hospital Boston, Louth and Grantham out of hours were initially assessed by the local on-call surgical team with support from the OMFS staff at Lincoln Hospital. This was completed by phone and OMF staff confirmed they had access to x-rays via the trust wide scanning system. However patients were not seen at these locations by the on-call surgeon based at Lincoln County Hospital and this may mean that potentially fractures were missed.
- Most patients were stabilised at the hospital location they had originally attended and were then booked for a next day clinic if this was needed.
- We did not find evidence of agreed pathways at senior surgical staff level for the post-operative care, for emergency and planned operations, of patients. This meant the care of patients might not be fully discussed or handed over between individual senior surgical staff on consecutive shifts.

Nursing staffing

- There were sufficient numbers of trained clinical, nursing and support staff with appropriate skills to

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deliver care and treatment to patients at the time of our inspection. However, we noted that there was a high use of bank and agency staff in the ward areas. This was recognised by the trust who has recruited over 100 nurses to fill vacancies. When we spoke with the matrons and ward sister for each service, we found that a majority of the vacancies were filled and they were waiting for the permanent staff to start. They expected staffing levels to be near establishment by the end of May 2014.

- The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- Daily staffing meetings discussed acuity and ensured that areas were fully staffed at all times. Staffing rotas confirmed staff numbers and skills mix were appropriately planned to meet the needs of patients. Staffing rotas confirmed that staffing levels in theatres were maintained in accordance with national guidance.
- There were a number of specialist nurses across the surgical division; these included a colorectal nurse consultant, advanced healthcare practitioners and a stoma nurse. However, although they supported the work of the ward nurses, it was not within their remit to fill any gaps in ward staffing.

Medical staffing

- It was agreed by stakeholders that there was a significant shortage of junior doctors placed at the trust. The shortages have meant that the surgery service operated a consultant-led service with ward rounds seven days per week in each area. During our inspection, we observed consultant-led ward rounds, handovers and teaching taking place on wards where consultants were visible. This had a positive impact on patients and staff. One patient told us, "I always see a consultant, which is good."
- Out-of-hours consultants for each service were contactable through an on-call system.
- At our unannounced inspection, we found that one junior doctor covered both medicine and surgery services. This impacted on patients requiring medical attention, and on other services such as A&E, for patient reviews. The trust was aware of the staffing concerns and have informed us through their action plans that they are working to address them.
- In 2015 we found that the OMF service had one Orthodontic consultant, who was permanently

employed, and a total of four OMFS consultants. Two of the OMFS consultants were permanently employed by the trust and two were employed on a long-term locum basis. The OMFS consultants operated a one in four on-call rota however we were not assured that handovers between on-call consultants were smoothly and appropriately completed between individual consultant surgeons. During our focused inspection we were not assured of the effectiveness of existing on-call arrangements due to absences in the senior surgical staff mix.

Major incident awareness and training

- Major incident information was available for all staff to access on the ward and was easily accessible. The service aimed to avoid the cancellation of elective surgery, but does have business continuity plans in place should emergency situations arise. This included the cancelling and rescheduling of surgery. The business continuity plans also included winter planning and preparation.

Are surgery services effective?

Good



Nationally recognised guidelines and pathways were followed and we found evidence of good multidisciplinary working. Clinical audits on relevant professional guidelines were undertaken regularly. The trust were under reporting the numbers of patients in the National Bowel Cancer Audit. This meant that they could not be assured of the quality of the service provided. The service had a well-established fractured neck of femur pathway, which provided a better outcome to patients than the average for hospitals in England. We found that the service worked to ensure that all surgeries were undertaken by the most appropriate surgeon, particularly when operating on patients with a cancer diagnosis, which is in accordance with the national standards.

The service provided seven day consultant cover across specialities. On the wards, there were consultant-led ward rounds occurring daily, seven days per week. However, during our 2014 inspection, we were not assured that seven-day-working for allied healthcare professionals across surgery services would be effective, due to a lack of staff to meet the cover demands of seven-day-working. In

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2015, we spoke to staff and the majority reported that that this was working effectively. We found there had been differences in clinical and professional approaches between individual OMFS senior surgical staff. We found significant tensions and a lack of multidisciplinary working by the senior surgical staff of the trust's OMFS service. The Trust has requested a review by the Royal College of Surgeons which was completed in January 2015. Final outcomes and recommendations were not available at time of our inspection

Evidence-based care and treatment

- Clinical audits included monitoring of NICE and other relevant professional guidelines. The hospital was eligible to participate in 35 national audits, 33 which, the trust participated in.
- Evidence-based guidelines and care pathways were used by surgical services, including the fractured neck of femur (hip fracture) pathway and the enhanced recovery programme for orthopaedic and colorectal patients.
- Under the CQC's intelligent monitoring programme, there were one surgical procedures flagged as 'at risk.'
- In 2015 we did not find evidence of full compliance with guidelines from the RCS or British Association of Oral Maxillofacial Surgeons (BAOMS). We found the service was not fully compliant with the Royal College of Surgeons (RCS) standards for unscheduled patient care for OMFS, published 2011.

Pain relief

- Patient records showed that pain scores were calculated and pain relief provided appropriately to patients. This included the use of patient-controlled analgesia (PCA).
- We found that pain relief controlled by epidural was not undertaken locally on the ward. Patients with an epidural in place were admitted to the intensive care unit for monitoring. Due to low numbers, it was deemed safer for patients to be nursed where competency in this area was high.
- We spoke with seven patients specifically about pain management. The majority told us that staff acknowledged their pain and they were offered regular pain relief. We reviewed the records of the patients, which confirmed that they were on the Abbey Pain Scale for pain monitoring. This supported what we were told.
- In 2014 we were informed by two patients that staff on Stow Ward did not always respond to their requests for pain relief. During our inspection, we observed a patient on Stow Ward who was crying. When we spoke with the

patient, they told us that they were in pain. The patient said, "I have been calling out for ages and no one comes". The patient was visibly distressed. We examined their records and found that their pain was not being monitored appropriately. We raised our concerns to the ward sister, who took immediate action to ensure the wellbeing of the patient. We found that this issue had been addressed at our unannounced visit. In 2015, we noted that improvement had been sustained; all records we looked at confirmed that pain relief was being administered and monitored regularly.

Nutrition and hydration

- We examined 26 records and found that all patients had a malnutrition screening assessment undertaken. Where appropriate, a referral had been made to the dietetic service. We identified that a bariatric patient had not been considered for a referral to dietetic services and there was no evidence of health options being discussed with the patient. When we returned on our unannounced visit we noted that this patient had refused referral to this service.
- We examined the food and fluid balance charts that were kept by the ward if a patient was deemed at risk and required additional monitoring. We found that these had been completed appropriately.
- We observed drinks being provided to people and others being supported with food at meal times.

Patient outcomes

- Lincoln County Hospital achieved 31 day and 62 day cancer waiting time targets. The medical director and clinical lead for the service are reviewing performance in this area.
- The colorectal service operates seven days per week, which is in accordance with NICE guidance. The seven surgeons had all completed more than 20 bowel resections per year.
- In urology, we found that 31-day treatment targets were achieved, with 96.8% of patients receiving treatment that was above the expected range. The service's multidisciplinary team (MDT) followed the East Midlands Cancer Network policies and guidelines, as well as national or international guidelines where possible. For example, the EAU guideline for Renal Cancer.
- The National Bowel Cancer Audit completed in 2012 showed that 97% of patients were seen by a clinical nurse specialist. The national rate is 82%. However, it also showed that 470 cases were identified in the

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hospital episode statistics database (HES) and the case ascertainment rate was 9%. The national rate was 95%. The trust were under reporting the number of patients in the audit and this meant that they could not be confident of the results. Since the completion of this audit, the trust implemented an action plan to improve ascertainment. The colorectal staff were clear in their responses and knew where improvements were required.

- The hospitals had no surgical mortality outliers at the time of the inspection, but since this time the trust have been alerted to an outlier in respect of aortic, peripheral, and visceral artery aneurysms.
- The trust scored in line with national performance in the national falls and bone health in older people audit in all but two questions. These related to administration of pain relief and the undertaking of a home hazard assessment.
- However in 2015 we found evidence of local audit activity which junior surgical staff had completed.
- We found an inconsistent approach to and participation in national audits by the OMFS service. The clinical lead for audits for OMFS had completed several audits however these had not always been nationally based audits for OMFS. We were unable to find evidence that these action plans had been fully implemented or learning from audits had been fully shared between individual OMFS consultants and other surgical staff.
- We did not evidence of recent compliance with or participation in national BAOMS audits by the OMFS service. Audits in which the OMFS service had not participated included delays in patient pathways, length of patient stay, 28 day unplanned readmission rates and patient outcomes despite recommendations for completion of audits in these areas. Additionally we found no evidence of audits completed, any audit action plans or outcomes for all aspects of fractured facial bones, including in poly trauma cases.
- OMFS services usually carry out parotid surgery procedures. We found the trust provision of parotid surgery was undertaken by three Ear, Nose and Throat (ENT) surgeons and one OMFS surgeon.
- The trust's website provided information about parotid surgery which stated ENT surgeons performed parotid surgery. We checked details of ENT surgeons listed as

performing parotid surgery but the trust could not confirm the information provided on its website was current and accurate in respect of parotid surgery procedures.

- The OMFS service and the trust did not collect surgical site infection rates although this is not a mandatory requirement and no data was made available in respect of a number of clinical procedures. These included infection rates for cases of prolonged bleeding, prolonged healing time of fractures and removal of plates or screws from internal fixation of fractures.
- The service did not provide data or evidence of screening pathways for hospital acquired infections for the OMFS service. These patients are screened as per the national/local policy and only high risk patients are included.

Competent staff

- The overall rate for appraisals for nursing staff in the surgical department was just over 75%. This was below expectations. We were told that this was to do with sickness rates and vacancies that meant staff could not be released to undertake this.
- A new appraisal process was due to be launched in April 2014, which included a simplified tool for staff to use.
- Medical staff across surgery have appraisals scheduled on a yearly basis. We spoke with four junior doctors about training and appraisals and all told us that they felt well supported and educated in their roles. They said that they knew when their appraisals were scheduled for. One junior doctor told us, "I am receiving some of the best education and support from this trust."
- Doctors from surgery identified to go through revalidation were being supported through the process. This was led by the clinical director, in conjunction with the medical director.
- In 2015 we found that administrative staff confirmed completion of appraisals had been sporadic and inconsistent. However nursing staff and junior doctors told us they had regular appraisals and felt they had received more support in the last four to six weeks prior to our focused inspection.
- Of the senior OMFS surgeons who had completed appraisals, some told us they did not have current job plans which had been recommended following their completed appraisals. OMFS surgeons completed revalidation procedures as required.

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- We were not assured the competency of all senior surgical staff had been fully demonstrated. We noted a restricted spectrum of surgical operations were undertaken by senior surgical staff. The Trust had initiated an internal and an external investigation and review of the clinical practices of members of the OMFS senior surgical team.

Multidisciplinary working

- We saw that there was effective communication between the teams within the surgical specialties.
- Allied Healthcare professionals worked well, with ward-based staff to support patient recovery and timely, safe discharge following surgery.
- Multidisciplinary team meetings were well established to support patient safety and a good recovery.
- At our inspection in 2015 we found that there were significant tensions within the OMF service in staff working together.

Seven-day services

- Allied Healthcare professionals commenced seven-day-working from 1 May 2014. This included pharmacy, occupational therapy and physiotherapy. We were not assured that seven-day-working for Allied Healthcare professionals would be effective, due to a lack of staff to meet the cover demands of seven-day-working in surgery. In 2015, we spoke to staff and the majority reported that this was working effectively.
- We found that, in the main, while there were shortages in the number of doctors available to work, seven day cover was available throughout the surgery service.
- On the surgical wards, the ward rounds were consultant-led seven days per week.
- Within the hospital, during night service, one doctor in training covered the Medical and Surgical Wards.
- In 2015 we found that on-call services were provided from LCH. Patients presenting at other trust hospital locations were referred as required to the on-call OMFS team at LCH for initial assessment. On-call staff could and did contact senior surgical OMFS consultants as required.

Are surgery services caring?

Good



We heard a variety of experiences of patients as to whether staff were caring. We saw some very good examples of caring staff, and some poor examples of care; the latter were predominantly on Stow Ward. We spoke with 16 patients and four relatives during our inspection, and people were mostly complimentary about the care they received across the service, except on Stow Ward. During our announced inspection, we found that the staff on Stow Ward did not always treat patients in a manner that was caring or respected their dignity. However, once we had raised our concerns, the trust took action, and patients during our unannounced visit on 11 May 2014 stated that the staff were more attentive and caring.

In 2015, we found that significant improvements had been made, particularly to the ward previously known as Stow. This ward had been moved and renamed as Shuttleworth Ward. We found that a period of intensive management and staff initiatives had brought about positive changes..

Compassionate care

- The NHS Friends and Family Test showed that the trust was performing below the national average in respect of relation to people who were likely or extremely likely, to recommend the ward to their family and friends. Eight surgical wards scored below the national average.
- We spoke with 16 surgery patients and four relatives at Lincoln County Hospital during our inspection and their comments were mostly positive about the care, treatment and support they received. They told us that the staff had been “very good”, “kind” and “hard working”. One person told us, “I think the staff here are wonderful, I cannot fault them.”
- We observed positive, kind and caring interactions on the wards between staff and patients. Staff spoke with patients and relatives in a dignified and caring manner. This demonstrated that staff in the majority of areas were caring and compassionate towards patients. The feedback we received from patients supported what we were told.

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- Call bells were answered in a timely manner on most wards. However, on Greetwell and Stow wards we observed call bells go unanswered for long periods of time.
- During our announced inspection in May 2014, we identified that staff on Stow Ward were not always caring or compassionate towards patients. We spoke with two relatives and four patients on Stow Ward during our inspection. One relative told us, “the staff here ignore the patients”. A patient told us, “the staff with the blue shoulders [nurses] don’t answer the call bells; they always tell the ones in the red [health care support workers] to answer them”. Another patient told us, “the ones in blue are not very nice. The ones in red are lovely”. A third patient told us, “when I need help and I call, no one answers. I can hear them standing at the desk giggling and laughing at us”. We raised this with the trust, who immediately took action to reduce the numbers of beds, so that staff had time to care. At our unannounced inspection, we spoke to patients and relatives, who felt that the care shown by staff had much improved. We also found this to be the case during our inspection in 2015. We found that Stow Ward was not in use, and that this had been moved and renamed to Shuttleworth Ward. All patients that we spoke with were complimentary about the care that they received. One person commented that their care had been “... brilliant” and a relative stated that staff had been “very helpful and caring”.
- During our inspection in 2014, we observed staff providing compassionate care, which respected people’s privacy and dignity. Call bells were answered promptly and patients needs were met.
- The majority of patients and relatives told us that they felt safe in the hospital. However, we received poor feedback on Stow Ward when we spoke with patients and relatives. Three relatives on Stow Ward told us that they did not feel that their relative was safe or well cared for. One relative told us, “I am worried, CQC come on the ward and things happen, but when you leave people just don’t get cared for”. Two patients also shared poor experiences with us, one patient told us, “please don’t leave me, I am scared of them”. We reported our concerns to the attention of the ward sister, matron and head nurse, for their immediate attention and action. At our unannounced inspection in May 2014, we visited Stow Ward, and found that the changes discussed with us had been implemented, and patients and relatives

reported improvements in care on this ward. In 2015, we found that in order to improve patient care and experience, a number of initiatives had been implemented. This included the introduction of an afternoon engagement ward round, where staff would specifically ask patients and relatives about their experience. We were told that this initiative had seen a complete reduction in complaints for the ward.

Patient understanding and involvement

- Staff respected the patients’ right to make choices about their care. The patients we spoke with told us they were kept informed about their treatment. They told us the clinical staff fully explained the treatment options to them and allowed them to make an informed decision. We observed staff speaking with patients clearly, in a way they could understand.

Emotional support

- Patients could access the multi-faith chaplaincy services for support. Information on how to access chaplaincy services was displayed on notice boards in the majority of areas we inspected. Staff told us they regularly interacted with the trust’s palliative (end of life care) team, who provided support and advice during bereavement.
- We found that the bariatric protocol and provision of ensuring the privacy, dignity and respect for a patient who was bariatric, had not been adhered to on one ward. The patient had not been consulted as to their needs, wishes or comfort with regards to their hospital stay. Patients who are bariatric should be offered emotional support to ensure their potential anxieties about open ward areas are discussed prior to admission. This would ensure their emotional and wellbeing needs are supported and could improve the outcome of their care. At our return visit, we spoke again to this patient. They had had their options discussed with them, but they remained in an area that did not respect their dignity.

Are surgery services responsive?

Requires improvement



Lincoln County Hospital was performing outside of the expected national average for cancelled operations. The trust overall was performing worse than the expected

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average, but there was a recovery plan in place to address this. In 2014 the bed occupancy rates for the hospital were higher than target ranges and this remained the case in 2015. We also found during this inspection that referral to treatment targets were consistently not being met across the service.

At our last inspection in 2014, we saw that one ward did not adhere to the policies on care for a bariatric patient. Equipment for bariatric patients was not always available. This was not responsive to patients' needs. In 2015, this ward was no longer in use, and we did not find any concerns in relation to the care of bariatric patients.

The surgery service displayed all risks and complaints in an open format on noticeboards in each clinical area, which could be viewed by the patients, public and staff. However, some risks, such as that of nursing a bariatric patient were not being met in 2014.

During our inspection of the oromaxillofacial service in 2015 we found that the service was not always as responsive as it could have been. Whilst patients attending the Lincoln County site were seen in a n appropriate timeframe those attending other sites may have experienced delays due to centralisation of this speciality across the trust.

Service planning and delivery to meet the needs of local people

- In 2014 the hospital was performing worse than the national expectation with regard to cancelled operations, compared to other trusts. An improvement plan to reduce the number of cancellations was in place, and from January 2014 the hospital has seen a steady improvement in reducing cancelled operations. Cancellations were mostly due to ward bed spaces being unavailable and staff shortages. In 2015, the hospital was still performing worse than the national expectations with regards to cancelled operations, with 202 being reported in the three month period preceding our inspection. 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 had a particularly difficult Winter period, with greater than anticipated demand.
- Vascular and spinal surgeries have been moved from Lincoln County Hospital over the past two years, which has affected patient access. This meant that patients

would be required to travel outside of Lincolnshire to receive the surgical procedures they require. One patient told us that they understood the constraints of the NHS, but it meant that they would have to travel far from home to receive their treatment.

- 16 beds were utilised within the surgical admissions area for overnight day surgery cases that were to be discharged the following day. This meant that the minor elective surgeries continued without the need for bed to be available on the ward.

Access and flow

- In 2014 the trust was not highlighted as a risk in respect of referral to treatment times for admitted patients. However, in 2015, the last three months of available data (September, October and November 2014) showed that, other than on one occasion, the trust failed to meet referral to treatment time targets of 90%.
- In 2014, Lincoln County Hospital was running a bed occupancy rate of 94% at the time of our inspection. In 2015, we found that improvements had not been made, with one ward confirming that they often ran at 98% bed occupancy. The trusts data demonstrated that this was the case across surgery, with the bed occupancy running at over 98% for the four months prior to our inspection.
- The SEAU was used to monitor patients requiring surgical care, while a bed on the ward became available.
- We found that there were substantial delays to a patient's timely discharge. This was due to a lack of bed spaces at care homes within the community and a lack of care packages for people's homes being available. For example, one patient had been waiting for a bed at a care home. This patient had been medically safe to discharge since 1 February 2014, yet they had remained on the ward for three months due to a lack of beds within the community.
- It was noted that there was a significant shortage of the therapists required to assess patients, as well as the pharmacists who arrange for the patients' medication to take home; this did not support the timely discharge of patients back to their own homes.
- We observed that the trust followed the NICE guidance for fractured neck of femur and set internal targets to ensure patients received surgery within 48 hours of injury, seven days per week. This clinical pathway was working effectively, achieving over 96% of surgeries within the 48-hour timeframe. This had been challenged

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by the complex road network around Lincolnshire. The trust was recognised nationally for its work and received an award for the effective care of patients with a fractured neck of femur.

- In 2015 we found that some clinical procedures and treatments were no longer carried out by Oral and Maxillofacial Surgery (OMFS) consultants at trust locations. Patients who needed these procedures were referred to other regional trusts. The trust had begun to scope and consult on the range and provision of OMFS services at trust locations. The trust had requested an Invited Review from the Royal College of Surgeons (RCS). The RCS invited review had been completed in January 2015. The final invited review outcome and recommendations were not available at the time of our focused inspection of the OMFS service provided by the trust.
- We found at our inspection in 2015 that urgent cases for referral to the OMF service were triaged by departmental administrative staff. They spoke with consultants to ensure patients who had been identified as being at higher risk were contacted and referred for their first appointment in a timely manner. Patients were generally seen within two or three weeks however if very urgent they could be seen at the next available clinic. Non urgent patients were seen within four to six weeks.
- Junior surgical staff told us when they were on call at Lincoln County Hospital (LCH); they had a logbook to record any referrals from the A&E at LCH or Pilgrim Hospital Boston, Louth and Grantham Hospitals. The logbook recorded information which was handed over between medical staff on-call shifts. We noted the logbook did not always contain information related to the patient or their referral to the service. This included times of referral and actions taken by on-call staff which meant accurate records of patient referral information was not always available.
- The referral and new appointment booking processes for patients at the trust were fragmented because there were different systems in operation for OMFS patients at LCH and PHB compared to patients at Louth and Grantham Hospitals. The trust did not effectively co-ordinate or manage the OMFS referral and new appointment booking systems for all its OMFS patients.

- There were dementia care champions within surgery. Staff had an understanding of who to contact if they required support.
- Learning disability Health Passports were in use to support consistent care for people with a learning disability. However, nursing and medical staff acknowledged that they had not received specific training in understanding learning disabilities and how to support people with limited communication abilities. They recognised that this was an area that they could improve on.
- In 2014 we found that some wards were not able to accommodate bariatric wheelchairs or mobility aides, due to the width of the doorframes. This was notable on Stow Ward, where a bariatric patient was admitted. We were told that the patient was not able to use their toilet due to the door frame not being wide enough. They therefore had to use the toilet intended for the opposite gender. The patient told us that they felt embarrassed by this. In 2015, we saw that Stow Ward was no longer in use, and a programme of remedial and redecoration works had been started within the service.
- We observed one person's care where the patient was deemed "challenging". However, we saw no evidence of discussion with the patient that demonstrated that they had been informed of their choices and their rights.

Learning from complaints and concerns

- The results of the NHS Friends and Family Test were displayed in ward areas showing what had been said and what had changed as a result of patients' comments.
- In 2014 we found that there was evidence that there was learning from complaints received in the notes of some ward meetings. Within each ward, the staff displayed the outcome and learning from any concern or complaint received on their noticeboards to show the public what improvements were being made. The action plans for improvement were monitored through the surgical governance and local ward meetings. At our inspection in 2015 we found that this system was not in place within the OMF service and that staff were not always aware of complaints in respect of the service.

Meeting people's individual needs

- Inpatient referral to treatment times were within the accepted range at Lincoln County Hospital.

Surgery

Are surgery services well-led?

Good



Staff were mostly positive about the trust and the leadership aims for the organisation, but felt there was still work to be done to achieve their goals for an improved service. The management team and directors were clearly visible, accessible and approachable within surgery. There were new clinical governance arrangements in place and these were beginning to embed.

In 2014 we found that the management team could not be assured of safe, effective care, as systems were not in place to ensure that issues were escalated to the appropriate managers. Managers were unaware of the risks in their area, such as the negative feedback from patients on Stow Ward. Medication errors were not reported, so managers were unaware of the risks to patients because of this. The department was not responsive to the needs of bariatric patients, as buildings, equipment and care provided to these patients did not meet their individual needs. In 2015, we found that managers had worked to make improvements, and positive change was evident throughout our inspection.

Managers were aware of risks in their areas, and a programme of refurbishment had been commenced. Improvements in incident reporting and learning were seen, and staff felt engaged. However within the oromaxillofacial service we found that there was no comprehensive, cohesive vision and strategy at local level. However there had been recent improvements in leadership and support of staff within the service. We found significant tensions, a lack of communication and multidisciplinary team working in the senior surgical team of the OMFS service. We found that there had been and continued to be a culture of non-resolution of identified issues in the OMFS service and senior surgical team. We found a breakdown in communications between individual members of the OMFS team, especially senior surgical staff, and between trust senior management with OMFS team members.

Vision and strategy for this service

- The trust vision, values and objectives had been cascaded across the surgery departments and staff had a clear understanding of what these involved.

- Information relating to core objectives and performance targets were visibly displayed in the majority of areas we visited. Locally, the surgery service had its own vision for development and improvement, which was discussed regularly at their governance meetings.
- In 2015 we found that the trust's OMFS service did not have a comprehensive, cohesive vision and strategy at local or trust wide levels.

Governance, risk management and quality measurement

- to drive improvement across the service. The meeting minutes did not clearly identify what actions were to be undertaken following each meeting. Therefore, there was little evidence in the minutes that demonstrated that all actions raised were being addressed. We found no evidence that the OMFS service complied with or actively interacted with the service's clinical governance team
- Each ward displayed a governance, risk and quality board, which was updated monthly. The board detailed the risks, complaints, incidents and trends for the service. There was also a staff board displayed in each area, which showed the mortality monitoring for the ward, staff training, appraisal, and local policy or procedural information. The board also contained local audits undertaken by department staff to improve learning. This meant that surgery services demonstrated clear governance and quality processes to improve the quality and delivery of care.
- Local senior managers were unaware of the issues on Stow Ward in respect of the negative feedback on the care staff, and in respect of bariatric patients who experienced a service which failed to meet their needs. In 2015, we found that managers had worked hard to make improvements, and positive change was evident throughout our inspection. Stow Ward was no longer in use and we noted that managers were aware of risks and issues in their areas.

Leadership of service

- Most staff reported to us that they respected their managers and told us that they felt supported by them. The head nurse, matron and clinical director were visible and accessible. However, staff commented that they did not always see a member of the executive team in the area, but they felt supported by the service leads.

Surgery

- The service had a management structure in place. Many of the band 6 and 7 staff had attended a leadership course to support their development through their employment.
- We spoke with the matron and clinical director for each specialty and the sister on each ward and found that they demonstrated clear leadership principles to the staff in the area. This included updating the relevant information boards and speaking with staff on an individual or team basis to improve the quality of service provided.
- Junior doctors also felt there were good opportunities for teaching and training. We noted that no concerns had been raised across surgery in the General Medical Council – National Training Scheme Survey 2013.
- In 2014, consultants were aware that juniors worked too many long hours. We were made aware that there was a significant shortage in the number of junior doctors placed at the trust by the Deanery, which was currently under review, and an action plan was being developed to address the shortages for the next rotation of junior staff. In 2015, we reviewed medical rotas and found that improvements to junior doctor staffing had been made, and that rotas were flexible to ensure all areas had the correct numbers of medical staffing.
- In 2015 we found that the local OMFS service leadership in the last five years had not been inclusive and was not effectively implemented or sustained. Nursing and senior surgical staff described the OMFS service as becoming progressively more unstable as a team, a department and a specialty.

Culture within the service

- All theatres were involved in the daily theatre briefing session. Every theatre sent a representative. Any issues for that day and the day before were discussed. This information was disseminated to all the theatre staff.
- Throughout our inspection, we observed that staff were very open with the inspectors and where things were not right this was acknowledged. This meant that we were assured that the culture within the surgery service was becoming more open.
- In 2015 we found significant tensions, no co-ordination, a lack of communication and multidisciplinary team working in the senior surgical team of the OMFS service. We found a breakdown of interpersonal relationships between senior members of the OMFS surgical team. Senior surgical staff reported a culture of obstruction,

harassment and undermining from other members of the team. We found an evident lack of professional respect and professionalism displayed by the senior OMFS surgical team which had deteriorated in the last five years.

Public and staff engagement

- In 2014, staff spoke with us about the Listening into Action™ groups that the trust held to address staff concerns. We received mixed feedback on the effectiveness of this group. Some staff were complimentary about the work the group was undertaking. However, several staff we spoke with felt this group was not yet effective, and that change was not yet being seen. In 2015, we saw that the Listening into Action™ groups had been active in implementing changes for the trust, and staff we spoke with were able to tell us about these initiatives and their impact.
- On each surgery, ward posters were displayed, encouraging patients and relatives to meet and speak with the matron and head nurse for the ward. This enabled them to provide feedback, whether positive or negative. However, they had not had great success with this scheme. The hospital was in the process of changing this to regular ward rounds to talk to patients and relatives. This process, they told us, was more successful at engaging the public to date.
- In 2015 members of the nursing and senior surgical OMFS service told us they did not always feel engaged by local and trust management teams. They told us they did not always receive feedback following concerns which had been reported to senior management teams at local and trust levels.
- We found a breakdown in communications between individual members of the OMFS team, especially senior surgical staff, and between trust senior management with OMFS team members.

Innovation, improvement and sustainability







- The 'plan for every patient' process meant that each patient's care was reviewed to ensure that all assessments had been completed, all MDT professionals that needed to be involved in care were and also planning was in place for the eventual discharge of the patients.
- Clayton Ward provided the surgery specialties of maxillofacial surgery, ENT and urology, which had challenging patient acuity levels to manage. The ward provided their case reviews and plans to evidence the

Surgery

need to split the ward and provide urology care, as a separate clinical area to meet patient demand was sustainable. The ward staff evidenced their rationale clearly, which will form a business case for the relocation of urology inpatient services to a separate ward. This meant that locally and at surgery management level the service was driving improvement for patient care.

- In 2015 we found the OMFS team and service did not have a considered, long-term approach to innovation or improvement to the provision of its services.
- The trust had started to explore closer working and support arrangements for individual OMFS surgical staff with external OMFS services and staff from other regional trusts.
- In particular, the trust had begun to consider a 'hub and spoke' approach to the provision of OMFS services by the trust, in conjunction with increased regional collaborative working practices.
- The local OMFS and trust senior management teams did not have an overarching strategy to innovate, improve and sustain OMFS services provided by the trust.

Maternity and family planning

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

Information about the service

The Lincoln County Hospital maternity service delivers around 3,600 babies annually. The maternity unit includes a labour ward (Bardney Ward), women's inpatient ward (Nettleham Ward), and an antenatal outpatients clinic, as well as an antenatal assessment clinic. There is a neonatal intensive care unit (NICU) and transitional care team, where babies who require additional support following birth are cared for. These services are reported under the children's services section of this report.

The service also provides community midwives who cared for women and their babies both antenatally and postnatally.

Summary of findings

In 2014 we found that the maternity service was caring. We received positive feedback from the majority of women that we spoke with. We were told that the service understood women's emotional needs, and that staff demonstrated a caring attitude while care and treatment was being provided. The service was responsive to people's needs. We found that clear pathways were in place to deal with women's individual needs, and that the service could be flexible to deal with demands. The service had a good incident reporting culture, and staff were aware of the key risks within the service. We found a similar picture at our inspection in 2015.

However in 2014, improvements were needed in relation to staffing, staff support, and leadership of the service. The maternity services were not working in line with national recommendations in relation to the numbers of maternity staff on shift. There were risks within the service, which meant that, on occasions, staffing levels were such that they did not promote safe care. Community midwives were also not staffed in line with current recommendations. Improvements were needed to ensure staff were appropriately supported. We found that mandatory training and annual appraisals had not been completed by a high proportion of staff within this service. At our inspection in 2015, we found that whilst the leadership had improved under the new head of midwifery, there were still improvements required in relation to midwife

Maternity and family planning

staffing and training, in order that the hospitals unit was in line with national and local targets. The trust had previously identified the presence of asbestos in the maternity buildings 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.

In 2014 we found that while there were good systems of governance in place, staff had not identified key risks and escalated these through a risk register. There was no clear vision in place for the service, and staff were not clear about how they kept up to date with developments within maternity. During our inspection in 2015, we found that a new head of midwifery (HOM) had been appointed across the trust in August 2014. Staff we spoke with were positive regarding the current leadership, and the strong focus on governance and risk management since this appointment. We found the service to be well-led and effective; however safety in the maternity unit at Lincoln County Hospital required further improvement, although developments had been made in some areas since the last inspection in May 2014. There had been numerous initiatives and improvements since May 2014, including the development of a monthly Trust Governance Team meeting followed by a Trust Business Unit/Senior Nursing and Midwifery Team meeting, to improve communication and manage risk more effectively across the hospital sites.

Are maternity and family planning services safe?

Requires improvement



In 2014 we found that the service had a good culture of incident reporting and learning from incidents. Staff were clear in relation to their responsibilities with regards to safeguarding. We saw infection control practices being adhered to, and equipment was safety checked. However, there was a risk that the shortage of midwifery staff could lead to negative outcomes for patients. Staffing levels in a number of areas were potentially unsafe. In 2015, we found that maternity staffing levels at Lincoln County Hospital and community services remain higher than recommended national guidelines. We witnessed long delays for patients between 8.30am and 1.30pm, as the antenatal assessment unit was routinely staffed by one midwife, which was not enough. We discussed the ratio of community midwives to women - 1:141 - which is much higher than the national guidelines, and was raised as a concern in May 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 to address this issue.

In 2014 we found that people's records within the antenatal clinic were left on display, and the environment was not conducive to safe working conditions. Due to problems with the building, some sinks could not be used. Therefore, improvements are needed to ensure that this service is working safely. 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 May 2014. In 2015, we found 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.

At our inspection in 2015, we found that medicines were not always managed in a secure environment. We saw intravenous fluids left unsecured, and the medicine fridge in the labour ward was unlocked and accessible to the public, which is a risk. We found mandatory attendance required improvement as recent figures remain low. Staff told us that long-term sickness rates and maternity leave were

Maternity and family planning

impacting on attendance, so allocated time to attend was also difficult due to caseloads and midwifery cover, especially in the community teams. These issues require further improvement.

Incidents

- As part of our 2014 inspection, we reviewed data for the past 12 months. We found that, in general, the maternity service at this hospital performed within expectations for a service of this type and size.
- We saw that incidents were reported and analysed at monthly governance meetings. The risk midwife and other members of staff had a good understanding of the themes being reported through incident analysis. The staff spoken with were able to talk to us about remedial actions being taken, such as auditing and improvement plans.
- One never event had been reported by the service in the past 16 months. This took place in November 2013. This is noticeably less than other trusts of a similar type and size. We reviewed the report, which was produced following a review into the causes of this incident. We noted that an action plan had been put in place and the outcomes shared with staff so that learning and improvement could take place.
- We saw that the service reviewed mortality and morbidity during regular clinical governance meetings.

Cleanliness, infection control and hygiene

- We noted that hand sanitiser and hand washing facilities were available for use within all inpatient areas visited.
- We observed general and deep cleaning taking place on the wards throughout our inspection.
- In general, all areas visited were seen to be clean.
- We noted that personal protective equipment (PPE) was readily available and that staff wore this where necessary.
- The NHS Safety Thermometer was also used to measure, monitor and analyse any harm that may have come to patients. This meant that areas of risk could be identified and dealt with.

Environment and equipment

- This hospital was first built in the 1970s, and there were challenges in relation to the set-up of the environment. At the time of our 2014 inspection, we were told that sewerage leaks within the hospital and, in particular, the antenatal clinic, had impacted on service delivery. We saw that various sinks and bidets on Nettleham Ward

had had to be marked as 'out of use' due to issues with the plumbing. They were covered over with black plastic bags. We were told that the estates department were aware of the issues, but due to there being asbestos within the building, remedial action could not take place swiftly.

- 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 May 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.
- In 2015 we saw 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. Asbestos removal work has already started at Lincoln County Hospital, which includes decanting wards to other areas whilst removal is actioned. This will also facilitate remedial work, hindered by the presence of asbestos, to various sinks and bidets on Nettleham Ward, which had to be marked as 'out of use' due to issues with the plumbing.
- The environment in the labour ward was not good. There was limited storage and no waiting area, with poor cramped shower and bathing facilities for patients. There was no clinical preparation room and we saw intravenous fluids left unsecured; the resuscitation trolley was unlocked and situated in the corridor, providing access to fluids which were in one of the drawers; and the medicine fridge was unlocked and accessible to the public, which is a risk.
- All of the equipment looked at had been serviced and cleaned within recommended timescales. We also checked resuscitation equipment, and saw that daily checks had been carried out to ensure that should these be needed for use, they were working correctly, and had all necessary stock available.

Medicines

- In 2014 we saw that separate areas were used for the storage of medications, and these were secured

Maternity and family planning

appropriately. However, during this inspection in 2015 we saw intravenous fluids left unsecured, and the medicine fridge in the labour ward was unlocked and accessible to the public, which is a risk.

- We spoke to people using this service, who confirmed that they been spoken with about the medications being given to them.

Records

- In 2014 we reviewed patient records for four people on Nettleham Ward and four people who were accessing the antenatal clinic. We found that all records were up to date and legible.
- Risk assessment were carried out when people first accessed the service. This ensured that women were seen by the correct people throughout their pregnancies.
- For the records reviewed within Nettleham Ward, we saw that a 'red-book' was present and these were completed as necessary, such as when a screening test has been carried out.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff who confirmed that patient consent would be sought prior to any procedures or tests being undertaken. From our review of records, we saw that patients had signed to give their consent where this was necessary.

Safeguarding

- At the time of our 2014 inspection, there was no named midwife for safeguarding. They had recently left the trust and recruitment was on going. During our inspection in 2015, the head of midwifery (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.
- There is a named nurse for safeguarding children and young people as the contact point for maternity-related queries.

- Staff received regular mandatory training on safeguarding.
- We were told that the service remained involved in any referrals made, and that feedback and support was provided to staff involved in these situations.

Mandatory training

- In 2014 some staff spoken with raised concerns about the processes in place which allowed them to complete mandatory training. We were told that some training was expected to be completed within people's personal time. This impacted on staff's work-life balance and morale.
- In 2015 we spoke to staff and reviewed mandatory training statistics, which previously showed in March 2014 that only 35% of staff on Bardney Ward and 38% of staff on Nettleham Ward had completed their mandatory training. We found mandatory attendance requires improvement, as recent figures remain low, such as Bardley Ward at 58%, Nettleham Ward at 50%, and community nurse attendance at 50%. Staff told us that long-term sickness rates and maternity leave were impacting on attendance, but allocated time to attend was also difficult due to caseloads and midwifery cover, especially in the community teams.

Management of deteriorating patients

- There were clear processes in place to deal with the deteriorating patient. In 2014 the service used a 'track and trigger' system, which was well understood by staff, and which we saw in use during our inspection. The 'track and trigger' system is an early warning system that looks at various clinical outputs from patients, such as heart rate and oxygen saturation. The outputs are graded and monitored, and clinical responses are actioned as needed.
- In 2015, the trust had moved from the 'track and trigger' system to the national early warning system. Staff confirmed they were receiving training on the national early warning system (NEWS) and were clear on escalating where a patient may be at risk. Practice simulations were being carried out on Nettleham Ward as part of the drills and skills training.

Maternity and family planning

Midwifery staffing

- We saw that handovers took place at least twice daily on both Nettleham and Bardney Ward. Both nursing and medical staff were involved in these handovers to ensure consistency with the care and treatment provided.
- In 2014 we found that escalation plans were not effective. We found concerns in relation to the level of staffing provided during the night on Nettleham Ward. This was because the ward area also housed patients who were being cared for by the transitional care team. At night the transitional care team (for mothers and babies needing an extra level of support) were not on shift, so this meant that midwives staffed to care for antenatal (including those undergoing induction of labour and early labouring women) and routine postnatal women, had their workload increased with more complex patients. In 2015, we found that the hospital had taken action to ensure that there were sufficient nurses on duty in this area at night time.
- In 2014, we also raised concerns in relation to the safety of staffing within the antenatal assessment unit. At the time of our inspection, between the hours of 5pm and 9pm, the unit was staffed by one midwife. The responsibilities of this midwife were to triage patients over the telephone, and also to deal with those women who required assistance coming through the door. There were concerns that an emergency could not be dealt with effectively with the level of staffing currently present. In 2015, we found that an additional midwife had been appointed to cover this period of time.
- During our recent inspection in 2015, we witnessed long delays for patients between 8.30am and 1.30pm, as the antenatal assessment unit was routinely staffed by one midwife, which was not enough. We looked at clinic book entries for three patients coming in for blood tests or assessments, who waited over two hours to be seen. Another patient for repeat bloods and monitoring had to go home and come back in the evening due to the delays. There were lists of patients to ring back, who had rung for advice over four hours ago. We were advised by staff that this is not unusual, with over 50% of patients experiencing delays. We raised this with the HOM during the inspection.
- While the Trust midwife ratio are adequate, maternity staffing ratios at Lincoln County Hospital and community services remain higher than recommended national guidelines, and require improvement. The

maternity departments had funding for ten additional midwives across the trust to facilitate improved birth to midwife ratio; however, Lincoln County Hospital remains high at 1:30. We discussed the ratio of community midwives to women, which at one midwife to 141 women is much higher than the national guidelines, and was raised as a concern in May 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.

- Workforce planning is to be undertaken, as currently there are 66.2 WTE community midwives across the trust, which is one midwife to just over 100 women, 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.

Medical staffing

- We found that medical staffing was in line with the RCOGs recommendations. This amounted to 60 hours of consultant cover per week and a lead obstetric anaesthetist.
- Many of the staff spoken with in 2014 told us about a new system called 'consultant of the week'. This meant that the same consultant was on shift for the entire week. This had shown a better consistency in the care that women received. In 2015, this was now embedded within practice.

Major incident awareness and training

- During our discussions with staff, we were told that emergency 'drills' were undertaken. These drills were described as a role play of a potential emergency situation. However, we found that emergency training was not undertaken within the antenatal assessment unit. This meant that some staff had not been enabled to keep skills up to date in order to deal with rare but potentially adverse incidents.
- Escalation plans were in place, which detailed actions to be taken in the event of increased patient activity or acuity or, in the event of an increase in staff absence.

Are maternity and family planning services effective?

Maternity and family planning

Good



In 2014 we found that the service had good processes in place to make sure that care was delivered in line with nationally-recognised good practice. Patient outcomes were monitored, and staff worked well together. However, improvements were needed to ensure that staff were competent to carry out their roles with appropriate access to regular appraisal and supervision. During our inspection in 2015, we found that the current ratio of 1 supervisor of midwives (SOM) to 15 midwives was satisfactory. Midwives were positive about the support provided, including a SOM helpline across the trust, providing advice and support to midwives and mothers 24 hours per day seven days per week. At this inspection we saw a marked improvement in appraisal rates, both for clinical and medical staff. Staff, including students and new starters, we spoke with noted good support from supervisors and the head of midwifery regarding professional development opportunities

Evidence-based care and treatment

- We saw that various clinical guidelines were in place, such as for the induction of labour. These were based on guidance produced by the NICE.
- We reviewed the local audit programme for the service and noted that various audits were being completed. For example, in relation to NICE guidance on cardiotocography (CTGs).
- We spoke with the risk midwife who confirmed that benchmarking the service against new guidance was undertaken by senior members of the maternity team.
- We were told that paediatricians undertook the physical examinations of newborn babies before they went home. This conformed to the NHS Newborn and Infant Physical Examination (NIPE) programme.
- The service had achieved level 2 in the UNICEF Baby Friendly accreditation scheme and was working towards level 3.

Patient outcomes

- We reviewed the maternity services dashboard. This document detailed the safety goals towards which the service was working. For example, meeting adequate staffing levels and monitoring clinical outcomes, such as the amount of women suffering a post-partum haemorrhage.

- In order to monitor capacity and acuity to ensure that good patient outcomes could be achieved, we noted that the service had been using the Birthrate Plus tool. The hospital's website had an area dedicated to services offered within the maternity unit. There was a good level of information about what women could expect when they received care and treatment at this hospital.
- We saw that the service had improved against its Commissioning for Quality and Innovation (CQUIN) target in relation to breastfeeding.

Competent staff

- Newly qualified midwives had access to the NHS preceptorship course.
- Staff told us that they had access to advanced life support training.
- A practice educator was available within the service.
- So that staff were able to keep up competencies in all aspects of maternity care and build their skills mix, we noted that a recent introduction of rotating midwives around the service had been introduced. For example, for three months a midwife would work on the labour ward and then rotate for another three months to care for antenatal or postnatal women.
- In May 2014, the service was not meeting national recommendations in relation to the amount of supervisors of midwives (SoM) that it had in place. In 2015, this has been improved and the current ratio of 1-15 is satisfactory. Midwives were positive about the support provided, including a recent initiative of a SOM helpline across the trust, providing advice and support to midwives and mothers 24 hours per day seven days per week.
- In 2014 we reported that except for the obstetric clinical lead, no-one had received an appraisal or work-based supervision for the previous year. At this inspection in 2015, we saw a marked improvement in appraisal rates, both for clinical (70%) and medical staff (89%). Staff, including students and new starters, we spoke with noted good support from supervisors and the head of midwifery regarding professional development opportunities.

Multidisciplinary working

- It was reported that midwives and medical grade staff had seen an improvement in the way in which they were working together. This had been helped by the initiation of having consistency within the medical grade cover.

Maternity and family planning

- Women had access to maternity care if they were staying in other parts of the hospital.
- There was good multidisciplinary working between the transitional care team and other maternity services.
- There were clear procedures in place to transfer babies to the NICU.

Seven-day services

- There was medical and anaesthetic support out-of-hours.

Are maternity and family planning services caring?

Good



The staff within this service were caring. We spoke with 17 people using this service and the feedback was mostly positive. Observations showed that people's privacy and dignity was met and that staff showed a caring attitude when speaking to and treating patients.

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

Compassionate care

- Women were enabled to maintain their privacy and dignity. While on the Bardney Ward, we noted that all doors and curtains were closed. On Nettleham Ward we saw that there was a mixture of single rooms and multiple-bed bays. In each of the multiple-bed areas we saw that curtains could be drawn when people required.
- However, when we visited the day surgical service where there was a termination of pregnancy (TOP) clinic operating, we observed that patient names were displayed on the doors outside people's rooms. This meant that the privacy and dignity of patients in this clinic was not respected.
- We spoke with 17 people using this service and the majority of feedback was positive. One person told us, "The care so far has been brilliant." Another person said, "I have no improvements to suggest, everything has been good."
- However, we did receive some negative feedback about the level of compassion shown by medical staff on the labour ward. One person commented, "The doctor was really unempathetic, [their] bedside manner was not to be desired."

- The service took part in the CQC maternity survey. Compared to other trusts, it performed at an average level.
- We saw that the service took part in the NHS Friends and Family Test and reviewed feedback on a monthly basis. We saw that responses were broken down and shared within the areas to which they related. For example, community care or labour ward experiences.

Patient understanding and involvement

- Patients spoken with told us that, in general, they had been given appropriate information about the care they would receive throughout their pregnancy. One person said, "I have been very well informed." Another person said, "All my questions have been answered and the staff have been friendly and attentive."
- However, some of those spoken with told us that they had not been able to see the same midwife in the community throughout their pregnancy. This meant that, on occasion, women would have to repeat information.

Emotional support

- We heard about the emotional support available to women when things went wrong in their pregnancies. There was a SANDS suite within the unit and women would be offered the use of a counselling service.
- We spoke with one patient, whose baby had unexpectedly been taken to the NICU following birth. They told us, "The staff have understood my anxieties and spent time providing reassurance and keeping me up to date."

Are maternity and family planning services responsive?

Good



The maternity service at this hospital was responsive to women's needs. There was good access to the service and women could contact the service 24-hours a day. The service could be flexible to meet different needs. For example, altering the amount of antenatal and postnatal beds.

Maternity and family planning

There were good care pathways in place, which met the individual needs of women. Women would be classed as 'low' or 'high risk' and those high risk patients were seen in clinic by a consultant obstetrician.

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

Service planning and delivery to meet the needs of local people

- We were told that the use of beds on the inpatient ward could be flexible to meet the demands of the service. For example, single rooms were available that could be used for women who had had a traumatic birthing experience. We were told that the use of antenatal and postnatal beds could be determined based on the needs of the service.

Access and flow

- Access into this service was made via a GP.
- Women had the use of a dedicated telephone line that was staffed by a supervisor of midwives 24-hours a day. There was also an antenatal assessment clinic that women could access if they had concerns about their developing pregnancy.
- All of the maternity services were located within the same area of the hospital, which promoted ease of access for patients.
- There were two dedicated obstetric theatres available. However, due to understaffing only one of these could be utilised at a time. This occasionally impacted on patient satisfaction and elective surgery lists.

Meeting people's individual needs

- When women accessed this service, they were seen in the antenatal clinic and a comprehensive assessment of their needs was carried out.
- We saw that various care pathways were in place to meet the individual needs of the patient. For example, if a woman had a raised BMI, they would be invited to attend a specialist group called "bumps and beyond" which provided care and information with regards to diet and nutrition.
- Other care pathways in place catered for: women with mental health needs, those with diabetes or previously known pregnancy complications as well as for foetal anomalies.

- The majority of the staff spoken with were familiar with the hospitals procedures for translation services. We were told that leaflets could be printed in different languages when the need arose and that, for more complex cases, a translator could be requested.
- A new birthing pool had been put in place on the labour ward and this was well received by both staff and patients.
- Discharge plans were discussed with women before they left hospital. We spoke to one woman who was being discharged on the day of our inspection. She told us that she was clear about the arrangements made for her and had been given everything she needed, such as medication and information prior to leaving the hospital.

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.
- We saw from our review of the clinical governance committee meeting that complaints were analysed and themes and lessons learned, shared.

Are maternity and family planning services well-led?

Good



In 2014 we found that there were clear processes in place for the governance of the service. Regular meetings were held to discuss areas of good practice and identify where improvements were needed. However, improvements were needed to ensure that all risks within the service were identified and escalated through the risk management process. There was no clear vision or strategy in place for this service. Not all staff were clear about how they could find out about developments and news regarding the service.

In 2015 we noted 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 and risk management since this appointment. The maternity vision and strategy was being developed, and linked with the wider health community, involving commissioners, providers and NHS England, for

Maternity and family planning

the future development and sustainability of the maternity service. A series of clinical discussion forums have been held to provide the opportunity for staff to input to the development of the clinical strategy, which is noted as good practice.

There has been development of the maternity risk/governance process since the last inspection in May 2014. Key risks were now being appropriately reported in the risk register, such as staffing shortages and the lack of specialist support in some areas. It was recognised that performance information required development, as extraction of data from the current IT system was not robust.

There had been numerous initiatives and improvements since May 2014, including the development of a monthly Trust Governance Team meeting followed by a Trust Business Unit/Senior Nursing and Midwifery Team meeting, to improve communication and manage risk more effectively across the hospital sites.

Vision and strategy for this service

- The maternity vision and strategy is being developed within the Trust Clinical Strategy Implementation Group (CSIG), and this is being linked with the wider health community via the Lincolnshire health and care (LHAC) process, involving commissioners, providers and NHS England.
- The ULHT Clinical Strategy Project Team for women and children's services has put forward to the CSIG two strategic options for the delivery of women and children's services in the future. Work has started on defining the detail and function of the service models. This process will also lead to the submission of business cases for the future development of the maternity service.
- Staff were not familiar with the strategy in May 2014. A series of clinical discussion forums have been held since then, to provide the opportunity for staff to input to the development of the clinical strategy. Some staff we spoke with were aware of this. Further discussion forums were planned for February 2015. The clinical strategy development has also been shared with the locality forums at each of the hospital sites, both in June 2014 and in December 2014. It was reported that the strategy development will continue to feature on future agendas of the locality forum discussions.

Governance, risk management and quality measurement

- The service held regular governance meetings where good practice was shared and issues relating to the service discussed. Action planning took place so that identified improvements could be made.
- In 2014 we found that the service had a risk register which was discussed on a regular basis. However, we found that key risks discussed with us during this inspection had not been escalated to the risk register, such as staffing on Nettleham Ward during the night. The matron for the service told us that this was to be put on the risk register imminently. From our review of the risk register, we also found that risks, in relation to the understaffing within the antenatal assessment clinic, had not been identified. At our inspection in February 2015, we saw that key risks were now being reported appropriately in the risk register, such as staffing shortages and the lack of specialist support in some areas. There had been the recent introduction of a maternity clinical risk team, comprising of two band 6 midwives and one band 7 risk manager, which staff noted had put more emphasis on risk management. A review of the operational maternity risk/governance process had been actioned since the last inspection, and minutes of risk meetings showed ongoing reviews of the maternity risk register. Staff were familiar with its importance and function.
- The head of midwifery was knowledgeable about quality issues and priorities, and understood what the challenges were, and was taking action to address them. It was recognised that performance information required development, as extraction of data from the current IT system was not robust. The HOM has submitted a business case for a maternity IT system to improve data quality.
- Staff were aware of the trust newsletter about performance information; a maternity newsletter was lacking at this time, although staff were aware of the maternity dashboard, which shows performance activity, such as number of births, and breastfeeding rates.
- Regular auditing took place, so that the service could measure its quality against patient outcomes. We saw that patient feedback was regularly assessed and reviewed, so that service improvements could be identified.

Maternity and family planning

Leadership of service

- In 2014 we spoke with the clinical lead, who demonstrated a good understanding of the service. This included current risks and areas that needed improvement, as well as areas of good practice.
- The clinical lead and matron for the service reported that working relationships between medical and nursing staff had seen improvement over the past months.
- A new head of midwifery (HOM) was appointed across the trust in August 2014. During our inspection in 2015, staff were positive regarding the current leadership, and the strong focus on governance and risk management since this appointment. It was noted that the HOM role was challenging, as it included the head of nursing for women and children's services as well.
- A new manager for the labour ward had been put in place, and staff commented that the management team and clinical staff had become more visible.







Culture within the service

- Staff we spoke with in 2014, told us that morale within the service was still quite low, but there had been improvements. However, in 2015 staff reported that morale was improving, with the appointment of the HOM, environmental changes being actioned, and additional staff recruitment.
- Staff were aware of the importance of reporting incidents when things went wrong and understood how this could influence service change and improvement.
- Staff told us that they felt they would receive feedback and support from their managers and team members where this was necessary.

Innovation, improvement and sustainability

- In order to make improvements to the service, the management team were aware of advances that it needed to make. We saw that a revised business case had been developed in order make the service sustainable, and give patients a better experience. At the time of our 2014 inspection, the trust had not made a decision on whether or not the business case should be accepted.
- In 2015, we identified the following developments since our inspection in 2014:
 - The facility change for the antenatal assessment clinic, from an isolated area to the annexe on Nettleham Ward, in recognition of lone working and clinical risk concerns.
 - Both maternity units are undergoing extensive work relating to the removal of asbestos and improving the environments (P21 Project).
 - The development of a monthly pan trust governance team meeting, followed by a pan trust business unit/ senior nursing and midwifery team meeting, to improve communication and manage risk more effectively.
 - A review of operational management of complaints.
 - A pilot of defined pan trust roles for women and children's directorate matrons.
 - Planning for specialist midwives roles pan trust.
 - A pan trust supervisor of midwives on-call rota.
 - Pan trust monthly supervisor of midwives meetings.
 - A birthing pool now available at both Lincoln County Hospital and Pilgrim Hospital.

Services for children and young people

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

Information about the service

The Lincoln County Hospital paediatric service cares for children up to and including the age of 16. The service included an inpatient ward with 24 beds (Rainforest Ward) and a day unit with six beds (Safari Day Unit). There was a NICU and transitional care team where babies who required additional support following birth were cared for. At the time of this inspection, the NICU did not have the appropriate staff in place with specialist skills in order for it to be operating as a fully established level 2 NICU. Agreement had been reached with the local neonatal network that the service could run as a level 2 unit for babies born from 30 weeks. This meant that the service could not care for babies born at 27 weeks as a fully operational level 2 unit would have been able to do.

In 2014 we visited all areas of the paediatric service. We talked to six children and their parents, and five parents whose babies were receiving care within the NICU, and a variety of staff. This included support workers, nurses, senior managers and the clinical lead. We observed care and looked at records relating both to patients and the running of the service. Before our inspection, we reviewed performance information from, and about, the trust.

In 2015, we visited all areas of the paediatric service. We talked with two parents and 11 members of staff. We were supported by one specialist advisor during this inspection. We also observed care and treatment, and looked at the records of three patients using this service.

Summary of findings

In 2014 we found the paediatric service was caring. We received positive feedback from the majority of children and parents that we spoke with. We were told that staff demonstrated a caring attitude while care and treatment was being provided. The service had a good incident reporting culture, and staff were aware of the key risks within the service. When we visited in 2015, the people we spoke with told us they could not fault the service. Throughout our inspection in 2014 we found that improvements were needed. We noted that the service was not staffed in line with current recommendations issued by the Royal College of Nursing (RCN). The service was also caring for patients with high dependency needs, which it was not commissioned for. This was impacting on the level of staff available to care for routine patients within the service. In 2015, we found 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.

In 2014 we found that evidence-based care pathways were lacking, and that equipment was not always checked appropriately. In 2015, we saw that evidence-based care pathways were being used, and that equipment had been checked and was safe to use.

In 2014 we found that improvements were needed to ensure that staff were appropriately supported. We found that mandatory training and annual appraisals had not been completed by a high proportion of staff

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within this service. A clinical supervision programme was also not in place. In 2015, we reviewed these areas again, and saw some improvements had been made. There were, however, some areas that required continued improvement.

Are services for children and young people safe?

Requires improvement



In 2014 we found the service had a good culture of incident reporting and learning from incidents. Staff were clear in relation to their responsibilities with regards to safeguarding. We saw infection control practices being adhered to and arrangements were in place to gain consent. However, we found a risk that a shortage of nursing staff could lead to negative outcomes for patients. Staffing levels did not meet national recommendations. Mandatory training had not been completed by a high proportion of staff, equipment had not always been checked and the environment on the NICU needed improving. In 2015, we found that there had been some improvements and that steps had been taken to close beds to mitigate the risks associated with staffing levels.

Incidents

- We saw that incidents were reported and analysed at monthly governance meetings. The members of staff spoken with had a good understanding of the themes being reported through incident analysis.
- We saw that serious incidents had root cause analysis and that the reports and outcomes were shared as appropriate. Action plans were put in place and monitored, to ensure identified improvements were made.
- No Never Events had been reported by the service in the previous 12 months.
- Reports were submitted to the service's governance meeting, which looked at paediatric and neonatal mortality. There were no concerns in relation to mortality within this service.

Cleanliness, infection control and hygiene

- We noted that hand sanitisers and hand washing facilities were available for use within all inpatient areas visited.
- We observed general cleaning taking place on the ward during our inspection.
- In general, all areas visited were seen to be clean.
- Regular infection control audits took place.

Services for children and young people

Environment and equipment

- In 2014 we examined the resuscitation trolley for paediatric patients in the theatre recovery area, to ensure that the equipment was safe to use and fit for purpose. We found that there were gaps in entries, which meant that the equipment on the trolleys was not always checked appropriately. This meant that patients were not always protected from the risk of avoidable harm. In 2015 we found that resuscitation equipment was checked as it should have been, and there were no gaps in the records used for checking this equipment.
- Resuscitation equipment on both the NICU and Rainforest Ward was checked appropriately.

Consent

- We spoke with staff, who confirmed that patient consent would be sought prior to any procedures or tests being undertaken. Children and parents we spoke with told us that they had been involved in decisions relating to the treatment offered to them.

Safeguarding

- A named nurse for safeguarding children and young people was in place.
- A lead for safeguarding was also present within each ward area.
- In 2015, 61% of registered nursing staff had undertaken level 3 safeguarding of children training.
- Where a safeguarding issue had been identified, this was highlighted within the patient record, both electronically and on paper.
- Staff spoken with were clear that there was a named safeguarding contact who they could contact if there were any concerns identified or raised.
- We were told that the service remained involved in any referrals made and that feedback and support was provided to staff involved in these situations. A safeguarding committee was in place, which looked at issues surrounding safeguarding within the service.

Mandatory training

- In 2014 we reviewed training records provided, and found that not all staff had taken part in training as deemed mandatory by the trust. When we inspected this service in 2015, we found some improvements had been made, but figures for the completion of mandatory training were still low within the service. The matron told us that training had been cancelled throughout

November and December, due to the Winter pressures on the ward area. They also told us that they were aiming to ensure they achieved their target of 95% for the completion of mandatory training by March 2015.

- In 2014, 16 out of the 43 members of staff (whose electronic records we reviewed) had undertaken safeguarding training. In 2015, we saw that 76% of staff on Rainforest and Safari Wards had completed their level 1 safeguarding children's training, and 69% had completed their level 1 safeguarding adults training.
- In 2014, nine out of 43 members of staff had completed infection control training. When we inspected this service in 2015, 78% of staff on Rainforest and Safari Wards had completed infection control training.
- In 2014 eight out of 43 members of staff had completed fire training. In 2015, 76% of staff on Rainforest and Safari Wards had completed fire training.

Management of deteriorating patients

- There were clear processes in place to deal with the deteriorating patient. Early warning score systems (EWS) were in place in the majority of areas visited. EWS are generated by combining the scores from a selection of routine observations of patients, for example; pulse, respiratory rate and consciousness levels. Where deterioration is seen, the score increases and early interventions can take place to stabilise the child's condition.
- The paediatric early warning score system (PEWS) was in use on the wards. We were told that this tool had only recently come into use. However, it had been well received by the members of staff within the service.
- PEWS was not in place within the A&E department. We were told that there were plans to ensure that PEWS was implemented by July 2014.
- The neonatal early warning score system (NEWS) was in place on the NICU.
- A paediatric resuscitation team was in place to deal with any emergencies within the service.

Nursing staffing

- In 2014 we found that Rainforest Ward was not staffed in line with national guidance, as recommended by the Royal College of Nursing (RCN). The recommendations state that one nurse should be on shift for every four patients – a ratio of one to four. We found that at best, staffing was at a ratio of one to six, and occasionally dropped to one to seven or eight. When we inspected in 2015, we found that Rainforest Ward was still not

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meeting the staffing requirements as set out in national guidance and recommended by the RCN. Management had taken steps to mitigate risks, and had reduced beds from 24 to 19. When all beds were occupied, this meant that staffing levels were at least one to five.

- In 2014 we had concerns about the level of staff on shift when the service was required to care for high dependency patients. At the time of our inspection, the service was not commissioned to provide high dependency care for patients requiring this service. However, on occasion, when staff were unable to transfer patients to another hospital, people who required more intensive treatment would be looked after within this service. This meant that because staff would be required to spend more time with one patient, there was a risk that other patients on the ward may not have received the care or support they required. When we returned in 2015, we found these concerns remained. We were told that the director of operations had commissioned a review of staffing, but the final report had not yet been published.
- In 2015 senior staff told us they were unable to fill gaps with bank and agency staff because paediatrics is a specialist service; the capacity to supply these staff was not there. They had, however, received an uplift to recruit a further five band 5 nurses, and interviews were due to take place the week following our inspection.
- We were told by senior members of staff that the staffing within this service was not adequate to the activity and attendance levels. This meant that consistent care was not being delivered. In order to address this, we noted that an acuity tool was being used to monitor and report on the impact of staffing.

Medical staffing

- In 2014 we saw that where a child who required high dependency care, and who was not intubated, was transferred to another hospital, staff from this service were required to accompany them. We were told that medical grade staff would often be utilised for this transfer, which meant that medical staffing within the service based at the hospital would be compromised. This meant that if there was an emergency, or a child needed assistance (specifically out-of-hours), there was a risk that their needs may not have been met appropriately. When we inspected this service in 2015, all staff we spoke with told us that it was very rare that a doctor from the service accompanied a transfer. Most

transfers were facilitated by a retrieval team from the receiving hospital. On the rare occasion that a doctor from the service was required to accompany a transfer, they would be covered by the consultant on-call, who would come into the service to oversee the care of patients on the ward.

- In 2014 the service was finding recruitment of medical grade staff difficult. This meant that there was regular use of locums within the service. When we inspected in 2015 we found that recruitment of middle grade staff had taken place, and a further 2.5 WTE middle grade staff had been recruited. There was, however, still a vacancy for 1 WTE middle grade doctor.

Major incident awareness and training

- In 2014 we found that the paediatric ward staff were not practicing any emergency scenario training. While staff had training in emergency life skills, we could not be assured that they were fully aware of how to deal with an emergency within the ward environment. In 2015 we found that emergency scenario training sessions had taken place to enable staff to gain knowledge in how to deal with emergency situations within the ward area. However, these sessions had been cancelled from November 2014 to January 2015, because the ward areas were busy due to Winter pressures. We saw that a number of emergency scenarios had been developed for staff to work through.
- On the NICU, we saw that staff used a simulator doll, in order to practice and keep up to date with lifesaving skills.

Are services for children and young people effective?

Good



In 2014 we found that the service had good processes in place to make sure that care was delivered in line with nationally-recognised good practice. However, at the time of our inspection, the service was not routinely monitoring its patient outcomes via a quality dashboard. There were also no evidence-based care pathways in place. In 2015 we found the service had only just started to collect data to

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monitor patient outcomes. The results were not available at the time of our inspection. We saw good evidence that care pathways were in place, and were being followed to ensure patients received evidence-based care.

Improvements were needed to ensure that staff were competent to carry out their roles, with appropriate access to regular appraisal and supervision.

Evidence-based care and treatment

- We spoke to a consultant who led audit activity within the service. We saw that there was a good clinical audit programme in place, which took into account NICE guidance, the requirements of the trust and standards set by the Royal College of Paediatrics and Child Health. Audit outcomes were discussed at an audit meeting, which had multidisciplinary involvement.
- The neonatal service was working to standards set within the Department of Health's Neonatal Toolkit.
- The service benchmarked itself against newly-issued guidance and the children and young person's outcome framework. We noted that the new guidance was discussed at local clinical governance meetings.
- As well as benchmarking itself against guidance, we saw that the service had benchmarked itself against other NHS organisations.
- Local audits took place at ward level. We saw that the ward staff undertook daily checks to ensure that the service could run effectively.
- In 2014 we found that there were no evidence-based care pathways or care bundles in use on Rainforest Ward. This meant that there was a risk that the service was not providing the most effective care to the children it was looking after. In 2015 we saw good evidence that care pathways were in place, and were being followed by staff to ensure patients received evidence-based care.

Patient outcomes

- The service had participated in a number of national audits it was eligible for. This included childhood epilepsy, paediatric asthma and paediatric fever.
- In 2014 the service was not using a quality dashboard to monitor and analyse patient outcomes. However, this had been developed, and plans were in place for its imminent implementation. When we inspected in 2015

we found the service had only just started to collect data to monitor patient outcomes. The results of the outcomes were not available at the time of our inspection.

Competent staff

- In 2014 we found there was no clinical supervision programme in place. When we returned in 2015 we were told that although there was no formal clinical supervision or one-to-one's taking place, there was an open door policy, and staff could always speak to senior staff if they needed to. Staff we spoke with confirmed that this was the case.
- When we inspected this service in 2014 we found that only 60% of staff had received an appraisal within the last year. When we returned in 2015 we found that 100% of staff had received an annual appraisal. Staff we spoke with confirmed that their appraisal had taken place.
- Staff had access to a link infection control nurse.

Multidisciplinary working

- It was reported that staff had seen an improvement in the way in which they were working together. This had been helped by the initiation of having consistency within the medical grade cover.
- There were clear procedures in place to transfer children between A&E and the ward. Staff reported good working relationships between the two services.
- We were told of the joint working between ward staff and the palliative care team where children came to the ward to receive care and treatment.
- Handovers were multidisciplinary, to ensure all staff had up to date information about the needs of children within the service.
- There was a multidisciplinary approach to audit and governance within the service.

Are services for children and young people caring?

Good



In general, this service was caring and compassionate. We found that the majority of people felt well-informed and that staff demonstrated a caring nature. However, there were a few negative comments received about the level of communication with the NICU.

Services for children and young people

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

Compassionate care

- We spoke with three women receiving care on the transitional care unit and they all told us that the care had been good. They told us that they had been kept well-informed and that staff demonstrated positive attitudes. One person commented, “They [the staff] have been absolutely fantastic.”
- Parents were able to accompany their children to theatres and recovery areas.
- The majority of parents on the NICU reported that staff demonstrated compassion and understanding. One person said, “Staff are generally friendly and compassionate and if you have a problem it is sorted pretty much straight away.” Another parent stated, “Medical grade staff are approachable and I feel like I can ask questions.” However, we did receive one negative comment where one parent felt the staff could be “abrupt and unsympathetic” at times.
- The children we spoke with on Rainforest Ward were all very complimentary about the care they had received from the doctors and nurses. One child commented “They [the staff] have all been very nice.”
- The NICU was the only service not taking part in the NHS Friends and Family Test at the time of our inspection. However, the service lead showed us evidence which demonstrated it did gather patient feedback by other means. It was however noted that the response rate was quite low.
- The CQC maternity survey undertaken in 2013 showed that the hospital performed averagely when compared to other NHS Trusts.

Patient understanding and involvement

- Parents told us that they had been kept up to date with their children’s needs. We were told that, in general, information was forthcoming and they did not have to keep asking for updates. Many of the children and families that we spoke with on Rainforest Ward were due to go home on the day of our inspection. They were all aware of the arrangements in place for discharge.
- Parents said they felt listened too and that their concerns regarding their child’s health had been taken seriously and their anxieties alleviated.

- Parents on the transitional care unit told us that staff were very good at keeping them up to date with their babies’ treatment. We saw that parents were enabled to tube feed their babies and undertake all normal parenting responsibilities.
- However, some negative comments were received on the NICU. One parent told us that they returned to their child to find that they were having blood tests, but that they not been informed of these tests or what they were required for. Another woman commented, “It’s quite clear that there are junior members of staff helping us, because the communication from them is not good.” They went on to say, however, “I can’t fault the more experienced members of staff.”
- Another set of parents we spoke with on the NICU told us that they felt they were not always listened too and that when they asked questions, staff were unable to explain appropriately.

Emotional support

- Parents said that staff were available to provide support to them when their children were very ill.

Are services for children and young people responsive?

Good



In 2014 we found that services for children and young people at this hospital were not responsive to the needs of the people that it was caring for. There was good access to the service, which was flexible in meeting the needs of patients accessing the service. However, improvements were needed in order to meet the individual needs of people accessing this service who require specialist mental health assessment and care. In 2015 we found that steps had been taken to ensure that the service was responsive to the needs of the children and young people using it.

Service planning and delivery to meet the needs of local people

- During our inspection of theatres in 2014 we observed that the paediatric recovery area was used by theatre staff to support both adults and children in the same

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area. We saw that there was no partition or separation between the adult and paediatric area. In 2015 we found that action had been taken, and there was a dedicated recovery area for children and young people.

- We spoke with the head nurse and senior sister in theatres at the start of the inspection, and we were told that children and adults did not share the recovery area. However, we also spoke with the staff members who were supporting the patients in the recovery area. They told us that this was standard practice. This meant that the practice of separating adults and paediatrics recovery was not clear. Therefore, the privacy and dignity of the patients in recovery was not always respected. This was because the mix of paediatric and adult patient areas was inappropriate.
- We were told that the beds within the service could be flexible in terms of the ages of the children that it held. For example, a cot could replace the bed should a young child be admitted to the service.
- In 2014, there were no adolescent services available. While a play area was in place for younger children, there was no allocated area where older children could relax or spend time. The trust's policy did, however, give patients between the age of 14 and 17 a choice of where they wanted to be cared for. In 2015 staff confirmed that patients between the ages of 14 and 17 were always given a choice of whether they would like to be cared for on the paediatric ward, or on an adult ward.
- In 2014 staff told us that every effort would be made to keep older and younger children in different areas, however, this did not always happen. We had received a complaint from a teenager who had had to share an area with a two-year-old child. In 2015, we saw that staff tried to ensure that older children and younger children were nursed in separate areas, and older children were given the choice where possible.
- In 2014 we observed the service was not in line with current guidance in relation the number of isolation beds it needed. When we inspected in 2015, we saw that the service had eight single rooms, which could be used for isolation purposes as required. Staff we spoke with were knowledgeable about the circumstances under which patients might need to be isolated.

Access and flow

- Patients could access this service as and when required. Patients would be admitted via A&E or children with long term health needs could go straight to the ward where they would be triaged.
- Children could also be referred to the service from community teams or their GP.
- Access to the NICU was within the maternity unit. This meant that babies requiring immediate interventions after birth had direct access to this service.
- Discharge meetings took place with parents and senior medical grade staff.

Meeting people's individual needs

- If the service cared for a patient with complex needs, such as a learning disability, they would be cared for within the paediatric service for longer than other children. For example, a person with learning disabilities could still access this service at 19.
- We were told that the service had input from a learning disability nurse for such cases and that the service would make sure the person's Health Passport (a document which contains key information about the person's behaviour's and likes and dislikes) was reviewed by all staff involved in that person's care.
- In 2014 we found that there was a lack of mental health input for children on the wards, particularly out-of-hours. This put additional strain on the service where a patient required one-to-one support due to a risk of self-harm. We were told that it was not uncommon for a child to arrive within the service on a Friday night and have to stay over the weekend without appropriate mental health support. This service was provided by the local mental health trust. In 2015 we found that improvements had been made to ensure that Child and Adolescent Mental Health (CAMH) services 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. The matron for the children and young people's services told us that they worked proactively with the CAMH service and the self-harm nurses.

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- The majority of the staff spoken with were familiar with the hospital's procedures for translation services. We were told that leaflets could be printed in different languages when the need arose, and that for more complex cases a translator could be requested.
- Patients with more complex needs were often cared for in one bay, which was closest to the nurse's station. This meant that those patients who needed extra support could be observed with ease.
- Daily ward rounds were carried out by consultant, so that patients' needs could be assessed and acted on appropriately.
- The environment within Rainforest Ward and the Safari Day Unit was well suited for the children being cared for. It was also well maintained. It was colourful and had lots of paintings and art work (done by children) on display. There were play areas in each unit.
- In 2014, the environment of the NICU Ward needed improving. There was a noticeable lack of wall art, and the areas seen were clinical and forbidding. In 2015, we saw that steps had been taken to make the environment brighter, and wall art had been used to make the environment more welcoming.

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.
- Complaints were discussed at the service governance meeting. Outcomes and actions were disseminated to staff through formal and informal meetings.

Are services for children and young people well-led?

Good



In 2014 the leadership of the service required some improvement in order that patients were kept safe, and were delivered effective care that was responsive to their needs. There were systems in place to identify issues; however, these were not always updated to reflect the current situation and action taken. Auditing took place, and feedback was used to improve the service offered. In 2015, we found that steps had been taken to mitigate risks to

patients; for example beds had been closed, and information was being collected about people using the service. We found that many of the residual concerns were related to the commissioning of the service.

In 2014 we found that whilst leaders were visible and supportive of staff, the lack of staff, mandatory training rates, and pathways for children, needed to be addressed by management to ensure a safe service for patients. We found that there was a lack of ownership for addressing the issues that the service faced. In 2015, we found that there had been a change in the management structure of the service, and staff felt they were being listened to. Whilst improvements needed to be made to the uptake of mandatory training, this had been impacted by Winter pressures and staffing levels. There was a plan in place to ensure all that staff were up to date with their mandatory training by March 2015. All staff we spoke with told us that they felt supported within their role.

Governance, risk management and quality measurement

- The service held regular governance meetings, where good practice was shared, and issues relating to the service discussed. Action planning took place so that identified improvements could be made.
- In 2014 we saw that the service had a risk register that was discussed on a regular basis. Although we saw that the key risks for the service were present on this register, we noted that it had not been updated with dates, such as when escalation had taken place, or when actions had been taken. In 2015 we saw that the local risk register for children's and young people's services had been updated, with evidence of controls that had been put in place. The risk register had also been dated when reviewed, and included a further date for review.
- Regular auditing took place, so that the service could measure its quality against patient outcomes.
- We saw that patient feedback was regularly assessed and reviewed, so that service improvements could be identified.

Leadership of service

- There was a clinical lead for the service. We spoke with this member of staff who was able to talk us through the key risks of the service and the areas that were being improved.
- A matron was responsible for the operational running of the service.

Services for children and young people

- A ward manager was also in post to provide leadership across the service.
- Staff told us that the manager of the service and senior medical staff were visible and approachable.
- In 2014 we found that issues such as staffing, attendance at mandatory training, and the development of the service through care pathways, were not being comprehensively addressed by the local management. In 2015 we found that local management were actively engaged in addressing staffing levels, and attendance at core service training, and the service was being delivered in line with clinical care pathways.

Culture within the service







- Staff we spoke with told us that morale within the service was generally quite good.

- Staff were aware of the importance of reporting incidents when things went wrong and understood how this could influence service change and improvement.
- Staff told us that they felt they would receive feedback and support from their managers and team members where this was necessary.

Public and staff engagement

- Staff were invited to take part in the Listening into Action initiative.
- Staff took part in regular staff surveys. The results of these were collated and analysed by the trust so that actions for improvement could be identified.

End of life care

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

Information about the service

The United Lincolnshire Hospitals have a Specialist Palliative Care (SPC) team that demonstrated a high level of specialist knowledge and service delivery. The SPC team was comprised of a palliative care consultant, three clinical sessions per week, two part-time McMillian clinical nurse specialists (CNS) and a discharge community link nurse. The SPC team had no administrative support.

During our inspection in 2014 we spoke with members of the specialist palliative care team, the porters, chaplain, Allied Healthcare professionals and nursing and medical staff on the wards. We visited a variety of wards across the trust including A&E Carlton Coleby Ward, Burton Ward, Johnson Ward, Lancaster Ward, Waddington Ward, the stroke unit, surgical emergency assessment unit, hospital mortuary, the porter's lodge and the hospital chapel. We reviewed the medical records of six end of life patients and observed the care provided by medical and nursing staff on the wards. We also spoke with five patients receiving end of life care and their relatives. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

Summary of findings

The specialist palliative care team provided positive information and advice to general ward staff on the care of the dying patient. However in 2014, the service was not well developed, and there was a disconnect between what managers wanted to happen, and what some of the palliative care team were undertaking. Patients using the service had only praise for the staff, and felt involved in their care. At our inspection in 2015, we found that this disconnect was no longer apparent, as staff within the specialist palliative care team now felt well supported by the trust. The team had begun to use patient demographics to drive service delivery, and training and implementation of palliative care link nurses was well underway.

In 2014 we stated that improvements to the service, in terms of ensuring the overarching strategy, were accomplished, addressing challenges within the completion of the DNA CPR form and the training of nursing staff on general wards, was required to ensure a safe, effective and responsive service. However, at our inspection in 2015, we found that significant improvements to training and overarching strategy had been implemented. The completion of DNA CPR forms still requires further improvement to ensure that patients who may lack capacity are protected when these decisions are made about their care.

End of life care

Are end of life care services safe?

Requires Improvement



In 2014 we found that staff reported incidents correctly, and undertook appropriate infection control measures. However, staff were not appropriately trained in delivering end of life care. DNA CPR forms were not appropriately completed, which meant that this aspect of the service required improvements to ensure that patients were safe. At our inspection in 2015, we found a similar picture, in that mental capacity assessments were not always undertaken prior to a patient being classed as DNA CPR. We found that staff training and awareness of mental capacity issues, and Deprivation of Liberty Safeguards, remained patchy.

Incidents

- In 2014 we found that incidents were reported to the matron, and entered on the online reporting system, Datix. The incident would be investigated (root cause analysis), and training would be arranged. For incidents such as not signing the prescription charts, staff and patients would be spoken to, to establish whether the medication was administered. The chart would then be retrospectively signed. However, when we followed this up at our 2015 inspection, we were told that retrospective signing of charts no longer occurred. Pharmacy technicians visited wards daily, and reviewed medicine charts. These incidents were reported on the electronic system.
- We found that systems were in place to learn from incidents. We were told by ward managers that discussions would take place at senior sister meetings. Incidents were then discussed at monthly ward-level meetings. Staff were able to discuss seven key subjects. We saw evidence that staff discussed wristbands, pain score, agency nurse check listing, poor handover of agency staff and the care plans of vulnerable adults at the ward meeting. Actions were discussed and put in place.
- On one ward we were told that all deaths are discussed at mortality meetings. A consultant undertook a case review to establish whether the patient was on the most appropriate pathway, the cause of death and if anything could have been done differently. Anything learned from the meeting was shared with frontline staff during ward meetings.

- During our visit the ward manager on the stroke unit told us of an incident that had occurred the previous evening with an end of life patient's discharge. The care and safety of the patient was dealt with immediately. The incident was reported following hospital policy. We observed the ward manager spending time with the patient's family.

Environment and equipment

- There was adequate equipment available in the ward areas we visited.
- There was no bereavement team available in A&E but the chaplaincy supported the families. A relative's room was available to allow relatives to sit when anxious and upset.

Medicines

- We were told by the ward managers that medication for end of life care was available on the wards. The ward manager on Waddington Ward was confident in the ability of the nursing staff to care well for patients with syringe drivers and often supported others across the hospital with any syringe driver queries.
- We saw that controlled drugs (CD) used for patients receiving care was stored as per national guidelines (Misuse of Drugs Regulations 2001) in a locked medicine cupboard secured to the wall. We checked the CD register and saw that drug entries were accurate and up to date. On the stroke unit, access to the medicine room was via a card reader. We observed that the daily temperature in the room was monitored.
- The CD registered was checked daily. A CD audit was conducted every two months to ensure the safe storage and usage of CDs.
- The hospital had a syringe driver policy in place, which had been developed working collaboratively with the community and the hospice. The policy was being reviewed at the time of the inspection.
- In 2014 the SPC team told us that McKinley syringe driver training was a 'hit and miss' situation. As many staff do not use the syringe drivers frequently, it was difficult to get staff released from the wards for training. Staff on Waddington Ward were often contacted to support staff on other wards. We were told that more "practical training would be appreciated". In 2015 we saw that the trust had significantly invested in equipment, and training was available for staff on the ward areas.

End of life care

Records

- Patient reviews were documented in the medical records and a photocopy of their consultations was kept by the CNS to refer to, if necessary.
- In 2014 we randomly checked six medical records containing DNA CPR forms. We saw that all decisions were recorded on a standard form with a red border. The DNA CPR forms were at the front of the notes, allowing easy access in an emergency. At our inspecting in 2015 we randomly checked 15 medical records containing DNACPR forms, which we found were completed on the standard form.
- Following the Keogh Mortality Review, the trust was told to redesign the form. The DNA CPR form in use at the time of the Keogh Mortality Review was a county-wide form, developed across community, ambulance and GP services. Since the hospital has changed the format of the DNA CPR forms, the new form has not been recognised by the community services. This has led to confusion and patient safety issues.
- In 2014 in surgery, we examined 12 DNA CPR forms, and found that in four cases, the patient's mental capacity had not been considered. This included one patient who was confused due to an infection. At our inspection in 2015, we found that in 10 of the 15 forms we reviewed, the patients mental capacity had not been considered; however, in four cases this was later assessed by hospital staff.
- In 2014 we found only two wards which had completed the DNA CPR forms correctly.
- In 2014 we found that one of the reasons for completing a DNA CPR form was recorded as 'frailty and older age'. When challenged, the doctors recognised that this was not appropriate. One consultant told us that they would take this issue to a meeting that afternoon. At our inspection in 2015 we discussed the issues with two doctors, who confirmed that they had received training in completing the DNA CPR forms.
- In 2014 we were told on Burton Ward that all patients receive the cardio-pulmonary resuscitation (CPR) patient information leaflet when CPR is being discussed with themselves or their relatives. We were shown that, on a daily basis, the wards do a check around the completion of DNA CPR forms. We checked that the findings of the audit were correct.

- Our findings in 2014 showed that DNA CPR forms did not always provide evidence that procedure had been followed. This indicated that more work was required in this area. We found similar issues at our inspection in 2015.
- On the intensive care unit (ICU) we saw comprehensive systems and processes were in place to support patients requiring end of life care, including 'the withdrawal of treatment protocol'. Staff could tell us about the protocols they followed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told by staff on the wards that Mental Capacity Act 2005 (MCA) assessments forms are available on the hospital intranet.
- In 2014 we found two occasions where the DNA CPR form had not been discussed with the patient, and there was no assessment of capacity within these records. On Burton Ward we reviewed a second set of medical records for a patient receiving end of life care. We found that DNA CPR was in place with a MCA assessment. We were told by the ward manager that all nurses are trained to perform MCA assessments and 'best interest decisions'.
- At our inspection in 2015 we asked staff about training in using the mental capacity assessment, and their understanding of use of the Deprivation of Liberty Safeguards. Most staff knew where to access this information, but demonstrated that training in this area was not consistent, with some staff not having attended training for three years. This is a similar picture to what we found at our previous inspection.
- We concluded that there was little evidence across the hospital that systems and processes were being followed around undertaking mental capacity assessments. Staff displayed a patchy knowledge of the process.

Safeguarding

- The trust had a 'safeguarding adult lead' who worked one day per week at each site. We were told that referrals could be made via mobile phone. We were told by staff that the safeguarding lead would walk the wards making themselves known to the staff and meetings with social services took place monthly to discuss cases.
- Staff had a good awareness of what abuse was and what actions they should undertake to protect their patients.

End of life care

- The safeguarding lead told us that safeguarding training to level 1 was available as an e-learning module.

Mandatory training

- In 2014 we found that there was no specific mandatory training in relation to end of life care. However, staff told us that they would appreciate some training with regards to administering medication via a syringe driver.
- At our inspection in 2015 we found that the SPC team were undertaking 'Train the Trainer' sessions using e-learning. We saw that there were two dates at each hospital. Training for syringe driver training was to be included in the intravenous infusion training.
- Since our last inspection, the trust has developed a questionnaire for staff to use, to identify their learning and development needs. This was designed by the SPC team and the hospice. The hospital has plans to audit the questionnaire once completed.
- We reviewed the competency of staff on four wards, and found that there were sufficient staff with training and competence in using syringe drivers to meet the needs of the patients on these wards.
- The palliative care consultant, in 2014, told us that a training programme was being developed to introduce mandatory end of life training for consultants. The training would include communication skills, improving general palliative care, discharge planning, and case studies. No date for the commencement of this training was in place.
- During our inspection in 2015, we spoke with two consultants, who told us that training packages on palliative care were available on the intranet through e-learning. These had to be completed by consultants prior to their annual appraisal. These consultants also told us that there were in-house study days, and that they received invitations to these.

Assessing and responding to patient risk

- In 2014 the SPC team told us that they could not be proactive, and struggled to influence the care of end of life patients on the ward, as referrals were not being made by the SPC team. When they were made, they are made too late in the patients' management. The SPC team felt that generalist palliative care was poor across the hospital. However, when we returned in 2015, the team told us that the policy for referral was now on the

intranet, and that this had been made easier to complete. We reviewed this form, and noted that 506 patients had been referred to the team in the past six months.

- In 2014, we saw no evidence of advanced care plans on the end of life patients' medical records we reviewed. This was confirmed by SPC team, who told us that very few advanced care plans are in place, as the SPC team are not reaching those patients receiving end of life care in the hospital. However, at our inspection in 2015, we saw that care plans for end of life care were in use in the ward areas; these were bright yellow and were obvious within the medical records.
- Following referral, patients referred to the SPC team on end of life care were reassessed on a regular basis, to ensure that the end of life care remained appropriate for the patients' individual needs. Patients were assessed and the level of support needed was decided. Patients could be seen once or twice a week, or every day.

Nursing staffing

- During our inspection in 2014, we asked ward managers about their staffing levels, and whether they had enough staff when they had to manage end of life patients. We were told by staff in some areas that there were no extra staff allocated to care for patients at the end of their life. In 2015 we saw that each ward had a palliative care link nurse, who advised other staff on the care of patients at the end of their life. In general, staffing on the wards had increased following the nursing review and increased recruitment.
- On Waddington Ward in 2014, we were told that at least two nurses must be chemotherapy competent. The sickness absence on Waddington Ward in April was 5.66%, and the rolling year rate was 6.23%. This is above average (national average 5.2%, Audit Commission, February 2011). At our inspection in 2015, we saw that the sickness absence rate for this ward was higher than the previous year, at 9%. However, the ward manager told us that there were four new nurses starting work in early March.

Medical staffing

- There was one palliative care consultant across the hospital.

Are end of life care services effective?

End of life care

Good



During our inspection in 2014, we found that staff were unsure as to whether to use the Liverpool Care Pathway (LCP), but some aspects of this were still in use. Support provided by the specialist palliative care team and the local hospice was utilised by the staff on all wards. Care for patients who were referred to the specialist palliative care team was good. However, ward staff did not have specialist end of life care training. The specialist palliative care team were only available five days per week, with advice and support available after 5pm from the local hospice. However, at our inspection in 2015, we found that the hospital had implemented and embedded the new documentation relating to care of the patient in their last days, and had provided training to all staff. There were 38 link nurses trained, and competent to provide advice and support at this site. Referrals to the SPC team had increased, and services were planned to commence seven day working in 2017.

Evidence-based care and treatment

- When we spoke to the SPC team in 2014, they told us that the LCP was still being used occasionally to support end of life patients across the hospital. After guidance from the Department of Health (October, 2013), the LCP must be phased out by the trust by July 2014. Staff we spoke with were confused as to the current situation with regards to using the LCP. At our inspection in 2015, we found that the trust now used documentation entitled Care of the dying patient in the last days of life to support care of these patients. This new documentation is in line with national guidance. Training in using this documentation was ward-based. We saw that 38 link nurses had been trained, together with 26 medical staff at this hospital.
- We saw evidence across all the wards and departments we visited that the SPC team supported and provided evidence-based advice to other health and social care professionals (for example, on complex symptom control), by undertaking one-to-one training (for example, with general palliative care training).
- The SPC team had introduced systems that enhanced the quality of life for people with long-term conditions,

such as complex symptom control, ensuring that people had a positive experience of healthcare, treating and caring for people in a safe environment and protecting patients from avoidable harm.

- Recently, the Leadership Alliance for the care of the dying released a statement (March 2014) to confirm that there will not be a national tool to replace the Liverpool Care Pathway. The palliative care consultant told us that a meeting was arranged for 14 May 2014 to develop Lincoln County Hospital's alternative to the Liverpool Care Pathway, which will include advanced care planning and the Gold Standards Framework programme.
- The SPC team input into the National Survey of Patient Activity Data for Specialist Palliative Care Services.
- The SPC team told us that the Clinical Commissioning Group (CCG) did not have a Commissioning for Quality and Innovation (CQUIN) in place around end of life care.
- We were told by the lead occupational therapist (OT) on the stroke unit, that partnership working with St Barnabas Hospice was being undertaken to review NICE Quality Standard 13 with physiotherapists and dieticians, in order to develop services around the quality standard. One action was to undertake an audit of the present service. We were told this would take place on 6 May 2014 by the therapy team. This showed that processes were being developed to ensure Streamline Therapy services will be in place across the hospital, hospice and community, to benefit palliative care patients.
- In the National Care of the Dying Audit of Hospitals 2014, Lincoln County Hospital did not achieve the key performance indicators in five of the seven indicators.

Pain relief

- In 2014, symptoms were managed following the Liverpool Care Pathway Symptom Control Guidelines. The palliative consultant visited the ward twice a week and advised on symptom management. The families were kept informed of any changes in the condition or management of their relative. We observed that discussions were written in the medical records.
- In 2015, we found that whilst the LCP was no longer followed, medical staff continued to prescribe treatment for pain and symptom control for patients within the palliative care service.

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Patient outcomes

- A national peer review self-assessment was undertaken in June 2013. The SPC Team scored a 'good' (64%).
- In 2012/13, Dixon Ward was involved in the phase 3 pilot of the Gold Standards Framework. We were told by the SPC team that due to pressures on the ward, and the need for end of life facilitators to support the programme, the pilot was withdrawn and had not been implemented. During this inspection in 2015, the SPC team told us that Dixon Ward had been offered phase 5, but the plan was to review the pilot, and use the prognostic indicators from the Gold Standard Framework, as these are working well in recognising the deteriorating patient.

Competent staff

- We were told by the palliative care team, that all extra training was on hold across the trust in 2014. The trust provided online end of life care training. We heard that some nurses had undertaken ad hoc training at local hospices, from the palliative care team. However, most nursing staff had not received training. However, at this inspection in 2015, we saw that training was available and undertaken by nursing and medical staff. This was a two year plan linked to Health Education England funding, and commenced on 15 February 2015. We were told it was an intensive ward-based learning programme. The course runs over four weeks, and is concerned with end of life care, with sessions/seminars on the ward approximately two to three times per week.
- The SPC clinical nurse specialists (CNS) were supported by Macmillan Cancer Care, where they could attend Macmillan teaching days, as well as being given financial support to attend other outside courses. Clinical supervision was received through Macmillan Cancer Care.
- In 2014 there were no palliative care link nurses on the wards to support and inform staff of best practice and the latest updates to keep skills up to date. A palliative care champion's programme was dropped by the trust at the end of last year. At our inspection in 2015, we found that 38 palliative care link nurses had been appointed, who had all received training to undertake the role. Most wards had a link nurse.
- The porters told us that they had received training to support the movement of deceased patients between the wards and the chapel of rest. The training included the use of the mortuary out-of-hours, to ensure that

mortuary procedures in and out-of-hours were adhered to. The porters we spoke to were able to describe the process in a knowledgeable manner, and were able to demonstrate that all patients were treated with dignity and respect.

- We spoke with the occupational therapist (OT) team leader, who had organised an end of life workshop, attended by OTs and physiotherapists, to share information and good practice. Areas covered included symptom management (such as fatigue, pain and breathlessness), hospital links with the community, fast-track processes, and managing deteriorating patients to maximise potential and quality of life. We spoke to a staff member who told us the workshop was "a really super course". By describing local processes, the staff member told us, "I know who to contact, which will help me to do my job more effectively".
- The outpatient's chemotherapy CNS supports training, namely one year's training for new band 5 RNs, and three to six months to train more experienced band 5 staff. This shows that the Lincoln County Hospital was mitigating workforce issues by supporting the training of staff.

Multidisciplinary working

- Systems were in place on the ward to ensure a professional approach to care was taken. An example of this was the pharmacist checking prescriptions against other data to ensure the correct doses were prescribed.
- The SPC team, with the lead palliative care consultant, conducted a multidisciplinary team meeting on Tuesday morning, each week. The patients receiving care under the team were discussed, along with any patients who had died during the week. Physiotherapists and occupational therapists attended this meeting.
- On other wards, we saw evidence of multidisciplinary team meetings being held to ensure that patients were receiving appropriate care.

Seven-day services

- We were told by the SPC team that systems were in place (such as shift patterns and on-call rotas) to provide timely SPC and advice at any time of day or night for people approaching the end of life or receiving palliative care who might benefit from specialist input.
- Patients could be referred to the SPC team via the telephone or pager, Monday to Friday, 9am to 5pm.

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Families could ask the ward staff to see the team. At our inspection in 2015, we were told that there were plans in place to recruit extra palliative care nurses to increase the support available to seven days per week by 2017.

- Out-of-hours, the St Barnabas Hospice would give advice and support to ward staff requiring support on symptom management. This meant that patients at the end of their life had access to specialist skills to support their palliative needs. However, we found that one ward was not aware of the out-of-hours support.
- The Chaplaincy provides a service five days a week, with the senior chaplain working every other Saturday and Sunday. An emergency call out service is available 24/7. Information was available on the hospital website detailing how to contact the chaplaincy and in the information leaflet given out by the SPC team, called: Information for Relatives and Carers.

Are end of life care services caring?

Good



Staff said end of life care was sensitive and caring. We were able to talk to patients and relatives that were receiving end of life care and generally the care received was good. Patients and relatives were involved in treatment options and generally felt well-informed.

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

Compassionate care

- Staff on all wards treated patients at the end of their life with dignity and respect. We heard a number of comments, including: “care [was] fantastic”, and that “if [my relative] dies here they will be more than happy” and “very good care and cannot find fault”.
- One family told us that the staff were “very accommodating and have made it very easy for us, the staff have given us china cups, my mum would have really appreciated the china cups”. We saw the patient was being nursed in a side room and we were told by the family that the ward staff were “coping well with our large family.”
- We were told by relatives that normal visiting times were waived and that they were able to visit at any time.

- We were told by the SPC team that car parking concession tickets were available to relatives when patients were on end of life care. This was confirmed by families.
- We observed staff on a ward providing care and support to a family whose relative was receiving end of life care. The family’s upset was recognised by staff and dealt with in a supportive and considerate manner. We spoke with one of the relatives during our inspection, who told us that, “They do care, and it feels to me like they mean it as well.”
- The SPC Team did not contribute to a local Bereavement Survey. The only feedback received by the team was if contact was made by families after the death of a relative. In order to develop services around the needs of patients, feedback needs to be received. The lack of administrative support prevents the SPC team from developing surveys and project work, due to the amount of non-clinical time that would be required to develop, analyse and write it up.
- The NHS Friends and Family Test results were advertised at the entrance of the wards we visited. On Navenby Ward, we observed their result was 69% in Greetwell Ward, 65% on Hatton Ward and 100% on Waddington Ward for March 2014. The positive comments on Waddington Ward included, “dedicated staff, friendly and helpful”. The NHS Friends and Family Test allowed patients and relatives to give feedback on the care and treatment received. It provided wards with an opportunity to develop services around patient needs.
- No complaints had been received that referred to the care provided by the SPC team. The palliative care consultant told us that they were involved in an advisory role to support ward staff in responding to complaints. The complaints received were generally about the care patients received on the wards before the SPC team got involved in the management of the patient. The SPC team received no feedback regarding complaints. This, we were told, was being followed up with, to try and use the data to support ward staff with training and education.

Patient understanding and involvement

- On Waddington Ward, we were told by the ward manager that families were involved in the care of their relatives at the end of their lives. In one example, we were told that a decision had to be made to place a patient on an end of life care pathway. After discussing

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this will the family, it was decided to continue medication for a further 24 hours and review. If there was no improvement, treatments would be withdrawn and comfort care would be given. In this example, the respiratory CNS was involved and not the SPC team. Individually, the family was spoken to and all conversations were placed in the medical records.

- We were told by the ward managers on Waddington and Carlton Colby Ward that families are asked “if they would like to be called if their relatives’ condition deteriorates”. This is documented in the patients’ medical records on the admissions sheet, where staff can assess the information easily.
- The ward manager on Carlton Colby Ward told us that “consultants are good at communicating with the patients and family” and do break bad news when necessary. This means that patients and families are being kept informed so decisions can be made around the planned palliative care.
- A family, whose relative was receiving end of life care on Lancaster Ward, told us that they had been kept involved in all aspects of their relative’s care. This showed that staff were keeping relatives informed.

Emotional support

- We found that the individual ward teams carried out the administration of a deceased patient’s documents and belongings. We were told by ward managers that after the patient had passed away, the relatives were free to stay with their relatives as long as possible. The relative was given a bereavement leaflet and told to phone the ward the next day to arrange the collection of the death certificate.
- The collection of death certificates usually took place the following day. Any delays in completing the certificates were kept to a minimum, as the nursing staff were able to get the doctors to sign the necessary documentation in a timely manner. However, the ward manager on Waddington Ward told us that delays do occur over the weekend when the availability of doctors was reduced.
- The mortuary manager told us that effective systems were in place to log patients into the mortuary. We were talked through the process. The mortuary manager told us that a 24-hour on call service was in place. A request for the quick release of a body could be accommodated to meet a family’s needs.

- The mortuary manager told us that they accommodate people of all faiths and worked collaboratively with Muslim undertakers to ensure deceased patients were cared for in accordance with cultural and religious requirements.

Are end of life care services responsive?

Good



In 2014 the service provided was not always responsive to the needs of local people. An example of this was that in planning the service, the local demographics had not been used to identify areas for improvement. Discharge planning was sometimes challenging, as staff did not always identify patients at an early stage. This meant that patients did not always die in a place of their choice. Some services were not available seven days a week at the time of our visit.

At our inspection in 2015, we found that the team were using demographic data to enhance the service they offered. Rapid discharge of patients was usually facilitated by rapid funding, which was usually received on the same day it was requested. This meant that more patients could choose the place of their death.

Service planning and delivery to meet the needs of local people

- In 2014 the SPC team told us that the ‘end of life profile’, which had information on the demographics of the local population that have passed away, had not been used for business planning and the development of future services. At our inspection in 2015, the team told us that they had started to use demographics to influence the services they provided.
- Most areas had a relative’s room, which could be used for relatives who were upset. On Waddington Ward, there was a relative’s room, which had been refurbished from charity money. The room was well-maintained and presented and contained facilities which included a shower and toilet, put up bed, comfortable seating, microwave, TV, fridge and tea and coffee facilities. Family members were encouraged to use the room when they were staying with relatives on end of life care, so that they had somewhere private to go when anxious, upset or when they needed time to reflect.
- We were told by staff on various wards that the hospital had relative’s facilities close by in the accommodation

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block, where visitors could rent a room for approximately £30 per night. We saw a notice on Navenby Ward advertising the facilities. We were unable to visit these during the inspection.

Access and flow

- All patients within the trust, requiring palliative or end of life care, have access to the SPC team, five days a week. In 2014 we were told by the SPC team that referrals consist of approximately 80% of patients with cancer, and 20% of patients who have other life-limiting conditions. The SPC team worked in partnership with the cardiac, respiratory and motor neurone clinical nurse specialists.
- The SPC team aim to review the patients within 24 hours. This was confirmed by staff on Waddington Ward, who reiterated the availability and effectiveness of the SPC team, and confirmed that the SPC CNS would appear the same day that the referral was made.
- The discharge community link nurse assesses and accepts patients for discharge under the Fast Track Pathway. This service is available Monday to Friday, 9am to 5pm. In 2014 we were told on Waddington Ward that referrals take one to two days. For patients who needed to go home to be cared for, the discharge community link nurse would facilitate the fast-track discharge process. A&E staff highlighted the difficulties of trying to discharge patients during the weekend. We were told by the ward manager that processes involved both social care and the police when unidentified people were brought into A&E. In 2015, we were told that this situation was improving, with access to fast track funding to care for patients in their own home. However, there were still some problems discharging patients across the county borders, as this could take some time to arrange.
- We visited the mortuary viewing suite, where families could go and spend time with their relatives. One hour appointments could be organised through the wards, Monday to Friday. The mortuary manager encouraged viewing in the afternoon, due to the workings of the department, but all requests would be met, if possible, according to the relative's needs.
- Access to the chaplaincy was 24/7. Out-of-hours, the chaplaincy could be made available to patients and staff via the ward staff, who could 'page' the chaplain.

Meeting people's individual needs

- In 2009, the trust was involved in the 'Delivering Choice Programme'. At the start of this programme 19% of patients were discharged to the 'preferred place of death' (PPD). At the time of the 2014 inspection, the figure sat at 42% within the trust.
- Systems were in place to facilitate the rapid discharge of patients to their preferred place of care. The discharge community link nurse explained that a professional approach was in place, which included an occupational therapist to secure rapid discharges to the preferred place of care. However, we heard that, on occasion, late identification made meeting patients' needs difficult. We saw one example of a patient waiting over a week to be discharged to a nursing home.
- The discharge community link nurse told us that referrals were dealt with, if possible, within 24 hours of referral and that they would stay to complete an assessment on a Friday night if a request was urgent. This was because the primary care coordination centre was open on a Saturday and Sunday.
- We were told by the ward manager on Carlton Colby Ward that translators were made available to staff where patients could not speak good English. We were given an example, where the use of translator, who was a member of staff, was able to improve the pain management of a patient at the end of their life.

Learning from complaints and concerns

- The SPC team had developed information leaflets for families whose relatives were receiving end of life care. The information available included "the hospital palliative team". On speaking to relatives, we were told they had received the information, which they found helpful.
- We asked what arrangements were in place to transport the deceased obese patients to the mortuary. Matron and the Chaplain demonstrated the concealment cover, which had been designed by the trust to allow obese patients to be transported in a respectful and dignified manner. The subject had been brought up by the 'dignity group' run by the chaplain. The cover was due to go clinical after discussion with the infection control lead. This showed that the teams were responding to the needs of all patients within the trust.

Are end of life care services well-led?

End of life care

Good



In 2014 we found that the vision for this service was not well known across the hospital. The specialist palliative care team felt that the hospital had not prioritised care at the end of life, and that this service required further development to ensure that patients experienced a good death. Whilst there was an executive lead for this service, there was no representative on the trust board, and this meant that this service was as well developed as it could be at this stage.

In 2015, we found that the vision could not be articulated by nursing staff in a number of wards. The executive with responsibility for end of life care now sat at the trust board. The service had been enhanced, and staff felt supported and recognised by the trust board.

Vision and strategy for this service

- The trust had a vision for end of life services, which involved closer working with the local hospice team. However, this was not known across the wards at our inspection in 2014. At our inspection in 2015 we found that whilst training had been undertaken, not all nurses knew of the vision and strategy for the service.
- There were joint appointments across the hospice and trust for medical staff. The palliative care nurses work closely with the hospice.
- There was an executive lead for end of life care.

Governance, risk management and quality measurement

- We found that the SPC Team and wards performed regular team meetings, in which performance issues, concerns, complaints, and general communications were discussed. Staff unable to attend would have minutes of meetings to refer to, and communication books.
- Matrons and ward managers were involved in weekly meetings, where complaints, incidents, audits and quality improvement projects were discussed. We were told that support was available from both the head of nursing and deputy chief nurse.
- Risks were regularly identified and flagged on risk registers at ward-level and at divisional-level.

Leadership of service

- The SPC team felt supported by St Barnabas Hospice, but in 2014, the hospital had not recognised palliative and end of life care as a priority; therefore, no management support had been given. However, this had changed with the appointment of an executive lead for end of life care. A business manager was to be appointed to develop the service. This would be a shared role with St Barnabas Hospice.
- In 2014 the SPC CNS's did not feel supported, as there was no lead nurse providing professional support since the lead cancer nurse left in October 2013. The SPC CNS felt that the palliative care consultant would support and was approachable, but as the consultant was only at the hospital for three sessions a week, their help was limited. At our inspection in 2015, the trusts were in the process of appointing to a lead nurse role to provide professional advice and support.
- In 2014 staff felt disconnected from the board and felt that there was little communication between frontline staff and the trust's senior members. We were shown the picture board of the executive team. We were told that this had recently been put up on the ward. In 2015 we found that the team felt that their important role had been recognised by the trust and they felt better supported.

Culture within the service

- In 2014 we found little evidence of palliative care involvement in the hospital's work programme. The SPC team were not included in the development or discussions of trust policy, such as in the development of the trust's pain or discharge policy. Their specialist knowledge was not being maximised by the trust to ensure informed policies were being developed. During this inspection in 2015, the SPC team told us that 'Quality for End of Life Care for All' have funded two nurses to provide training to staff who will work at the local hospice, and with the hospice at home team, to increase their knowledge and understanding of end of life care and the different services available.
- Quality and patient experience was seen as a priority, and everyone's responsibility, and this was evident in both the SPC team and the ward staff, through their patient-centred approach to care.
- In 2015 we found evidence on the wards that staff had received end of life care training.

End of life care

Public and staff engagement







- In 2014 we found little evidence of public or staff engagement in end of life service development. In 2015, consideration was being given as to how patients and staff could impact upon the service received.

Innovation, improvement and sustainability

- The SPC Nurse gave examples of practice that the team were proud of, providing a holistic approach to patients

receiving palliative or end of life care; streamlining processes between the hospital and the community, comprehensive weekly MDT meetings and the development of clear processes for the fast-track discharge.

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

Information about the service

Outpatient services (OPD) at Lincoln County Hospital are located on two levels and can be entered through the main entrance of the hospital. The outpatients department is divided into medical and surgical outpatients. There are eleven outpatient areas, which have their own reception areas.

The trust offers outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up are required. Lincoln County Hospital offers clinics in paediatrics, general surgery, respiratory, rheumatology, diabetes, gastroenterology, urology, cardiology, ear, nose and throat (ENT), haematology, neurology, orthopaedics, Maxillofacial, dermatology, plastic surgery and urology.

During our inspection in 2014, we spoke with five patients, two relatives, and 20 members of staff. Staff we spoke with included: reception and booking staff, clerical and secretarial staff, nurses of all grades, doctors and consultants. We observed care and treatment. We received comments from our listening events, and we reviewed performance information about the department and trust.

In February 2015, we spoke with seven patients, two relatives, and 15 members of staff. Staff we spoke with included reception and booking staff, clerical and secretarial staff, nurses of all grades, doctors and consultants. We observed care and treatment.

Summary of findings

In 2014 we found that patients received good care; the systems to support the services were judged to be inadequate. The lack, and condition, of medical records, training of staff, and issues with the building, needed addressing by the hospital. The department was very busy, and did not have enough space for all clinics. This meant that some clinics could not provide a service other than in routine hours. Cancellation of appointments was a frequent occurrence, and this was due in part to lack of medical records. The new outpatient booking system was not generally well liked by staff or patients, as they felt that their appointment would be lost in the system.

Staff were aware of the risks, and they took daily action to mitigate these. The overcrowding and overbooking of clinics was a significant issue for patients. Information was provided to patients through leaflets and posters on the walls. However, access to magazines and books were limited. Cancellations, car parking charges (excessive due to long waits), and waiting times were amongst the most frequent complaints from patients.

In 2015, we found some improvements with the condition of medical records; however, the issues regarding space and capacity for outpatients remained a concern. The trust has shared with us their plans to increase the physical capacity and improve the environment for patients. Appointments were frequently cancelled, and for those specialties where demand exceeds capacity clinics were routinely overbooked. The

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change-over to a new patient administration system (PAS), the trust did not have validated numbers of how many people were awaiting appointments, and the risk of patients becoming lost in the system remained.

Overcrowding and overbooking of clinics remained a significant issue for patients. Car parking charges (excessive due to long waits), and waiting times were amongst the most frequent complaints from patients. Most patients we spoke with about car parking charges raised concerns, and we identified that this appeared to have not improved since our inspection in 2014.

Are outpatients services safe?

Requires improvement



In 2014, whilst there had been low reporting of incidents within the outpatients department, the systems and processes to support this were judged to be inadequate. Patients' medical records were not always available, resulting in cancelled appointments. When they were present, it was often difficult to find information due to the size and condition of the record.

The building required refurbishment to make it safe for patients to access, and to ensure their safety once in the building. Staff training was also not consistently at the required level to ensure treatment of patients by competent staff.

During our inspection in 2015, we identified that there were safety issues with the number of patients in the Patient Administration System (PAS) who may not be identified as being in need of an appointment. The trust had changed their patient administration system, which increased the concerns, and a computer systems recovery has not yet been made to identify all patients who are waiting in the system. This meant that patients in need of a follow up appointment may be missed and cannot be identified. The monitoring of this system was in its infancy, and overall the safety of patients waiting for an appointment was inadequate. We raised this with the senior managers at the trust and they undertook a review which provided some reassurance that actions were being taken to address this issue and provided a full action plan for on-going work to resolve the issue.

The number of reported incidents had slightly improved, with more events being reported; however, further improvements in the incident culture were required. Patient records were not available for 12% of clinics on average, which was an improvement since our inspection in 2014.

The dermatology and maxillofacial services were undertaking significant surgical procedures, including wide excisions, skin grafts and skin flaps, in the procedure rooms within outpatients. The environment within these rooms was not compliant with requirements around air flow and

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infection control, and placed people at risk of developing an infection. This was escalated to the Director of Operations who immediately stopped these procedures being provided in those rooms.

Incidents

- The outpatients department had not reported any 'never events' in the previous year.
- In 2014 the department had a low rate of reporting incidents; however, this is not uncommon in this type of department. In 2015 we found that the number of reported incidents had slightly improved, with more events being reported; however, further improvements in the incident culture were required.
- Staff were aware of how to report incidents and they had received training in the process of reporting incidents using the online reporting tool. Incidents included: misfiled patient records, late starting clinics, and patient falls.
- The OPD manager told us that they would feedback any learning from incidents and accidents to staff. A Datix folder was maintained by the clinic sister to monitor any trends in the incidents. The manager told us that staff meetings were held monthly to give feedback to staff. If attendance at the meeting was poor, staff would be informed via email and a copy of the minutes made available for them to assess.
- In the last three years, there had been no serious untoward incidents and Never Events in the OPD.
- In the rheumatology clinic, the clinic sister was able to talk us through the incident reporting process by illustrating an incident that had happened in the clinic. A Datix report was raised and the business unit investigated. The findings were shared with the staff to prevent a similar incident happening again. This showed us that systems were in place to manage incidents in a structured, timely manner.

Cleanliness, infection control and hygiene

- We observed that effective systems were in place to reduce the risk and spread of infection across the clinic areas. These included the use of 'I am clean' stickers and appropriate audits, including ensuring that all staff adhered to infection control principles and regular cleaning schedules.
- In the rheumatology clinic, we observed an infection control board in the patient waiting area. For MRSA, the clinic had met its target of zero and the C. Difficile target was less than 62, actual seven.

- Compliance with the hand hygiene audit was 100% for April 2014. Hand hygiene audits were performed weekly.
- A site infection control group, chaired by a medical consultant and infection control link nurses, ensured that action was taken to address issues raised.
- Staff wore personal protective equipment, including: eye protection, plastic aprons, mask and gloves.
- All staff had received their mandatory annual infection control training.
- Nursing staff that we spoke with demonstrated a good understanding of infection control and of their roles in preventing the spread of infection.
- In the ear, nose and throat clinic (clinic 6), we were given a demonstration of decontaminating the 'nasendoscopes'. These are used to examine the nose, throat and voice box and require disinfecting after a single use. All endoscopes were decontaminated in outpatients. While appropriate procedures were in place, these were decontaminated by hand. The decontamination room required redesign to ensure separation of clean and dirty areas. This had been placed on the hospital's risk register, as it was highlighted as an area requiring improvement.

Environment and equipment

- We saw evidence that adult resuscitation equipment stored in the department to assist staff during an emergency had been checked regularly by staff. However, in the rheumatology clinic, we noted that the trolley had not been checked one day in the week prior to the inspection.
- We saw evidence of a health and safety audit undertaken within the OPD, but we observed that actions had not been undertaken. Staff we spoke to were unsure why this had not happened. One sister told us an action had been actioned, but that it had not been documented appropriately. We observed in one area that there were concerns regarding clinic rooms that did not have windows or ventilation. These rooms were used to conduct consultations. This has been escalated on more than one occasion, but we saw that no actions had been taken to date.
- In the rheumatology clinic, we observed that half a ceiling tile was missing and wires were clearly visible. We spoke to the clinic sister, who told us that this was due to a previous leak on the roof and that a bucket had

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been used to catch the rain. She said that the clinic room had been sealed off, however, it was noted that all the patients had to pass the leak site to get to the treatment room.

- During our 2015 inspection, within the outpatient clinic of dermatology, we identified that the service was undertaking procedures in the minor procedures room that were not appropriate due to the environment of the room. The service was undertaking wide excisions and skin grafts in the room. These procedures should be undertaken in rooms that have sufficient lighting, air flow and ventilation defined by the HBN 26 facilities for surgical procedures volume 1 and Health Building Note 10-02 Day surgery facilities.
- We were later informed that the maxillofacial department was undertaking flap procedures in the minor procedures room; this room again did not meet the minimum requirements as defined by the guidelines above.
- We raised our concerns directly with the director of operations, who took action by informing staff that no further advanced surgical procedures will be undertaken in those rooms until they have reviewed the guidelines.

Medicines

- Medicines were stored correctly. We saw the records demonstrating that fridge temperatures were monitored daily and all records confirmed the fridge was working within the specified temperature range.
- FP10 Prescription pads were stored in a locked cabinet. When clinicians wrote patient prescriptions, the OPD kept a log that identified the patient, the doctor prescribing and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.

Records

- No electronic records were available across the trust and the physical condition of the paper records was poor.
- In 2014 the storage of the medical records was on Lincoln County Hospital's risk register. Also documented was an issue with the merging of patients' medical records, which had resulted in multiple sets of records. During the inspection, we observed piles of medical records in the medical secretary's room.
- In the rheumatology clinic, we observed that the patients' medical records were stored in the clinic, as

patients would be attending for a course of treatment. The healthcare assistant pulled the medical records for each clinic. All records were tracked on the hospital management system. We were told by staff that there were no issues regarding obtaining patients' medical records for clinics.

- In 2015 we found that the records were going through an overhaul, with notes being merged and refilled, so that they were smaller and easier to manage. At the time of inspection there were approximately 9,000 records going through the improvement process, almost 5,000 of which had completed the process. Staff we spoke with informed us that they were beginning to see improvement in the quality of the records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with the trusts safeguarding lead, who told us that under the best practice guidelines, Mental Capacity Assessment 2005 (MCA) forms should be undertaken by two healthcare professionals, with one being the decision maker.
- In 2014 we checked two forms and saw that these were not filled in correctly, as two professionals had not completed the form. In 2015 we observed that mental capacity assessments were not being routinely undertaken. Staff had received training in safeguarding; however, their knowledge of the Mental Capacity Act 2005 remained limited.
- We observed that the safeguarding team did not keep copies of the mental capacity assessments undertaken, or audit these to ensure compliance.
- We saw evidence that patients were being asked for consent in line with hospital consent policy. We reviewed three 'consent forms 1' (which is used for those who are able to consent) and found that a description of the procedure to be undertaken was described, along with the benefits and risks. The forms were signed and dated by the health professional and the patient.

Safeguarding

- We observed the safeguarding adults telephone advice sheet for three people and noted these were very well documented and were in-depth.
- The hospital has a 'whistleblowing policy'. We were told by matron that staff are asked to raise concerns with their clinic manager initially, but can go to the matron if preferred.

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- We were told by the safeguarding lead that due to staff shortages, training had been postponed. It was therefore anticipated that safeguarding training would take place on a full day; which, it was anticipated, would be easier to manage for staff.

Mandatory training

- We saw the mandatory training records for the medical OPD, dermatology and clinic 7 for April 2014. We observed that for core training, which included infection control training, fire and manual handling was 100%.
- In the surgical OPD, we reviewed the training records. The mandatory training varied across the clinics with clinics 4 and 9 achieving 100%. However, in clinic 11 it was 40%, clinic 8, 38%, and in the preoperative clinic it was 62.5%.
- Safeguarding adult training level 1 was 81.2% for Medical OPD. However, in the medical day unit it is only at 40%. We spoke with nursing and HCA, who told us they had undertaken level 1 safeguarding adult training and that some had also undertaken their level 2 safeguarding training. However, we were advised that further roll-out of the level 2 safeguarding training was anticipated over the next few months, when a new member of the safeguarding team was due to commence work at the hospital, thereby bringing the team's numbers from one to two. The trust had to release staff for training. One member of the administrative staff told us that they had received no training.
- In 2015 we reviewed the training records within each of the clinics, and noted an improvement across all in receiving mandatory training, with over 70% of staff receiving training across all clinics. Where staff had not received training there were valid reasons, such as sickness or maternity leave.

Nursing staffing

- In the rheumatology clinic, we were told that four nurses were on duty between 8.30am and 4.30pm in the treatment room and that no agency staff were used, due to the competencies required by the nurses.
- Where staff were absent, they were replaced either by staff within the department who would work extra hours or alternative shifts; or the department gave shifts to particular NHS professional staff who had been trained in the competencies required to work within the department.

Medical staffing

- The medical cover for clinics was arranged within the divisions, who agreed on the numbers of clinics and patient appointment numbers. The divisions had provided the appointment teams with templates, which showed where appointment spaces were available.

Are outpatients services effective?

Not sufficient evidence to rate

Outpatient clinics used national guidance to support their work. However, the number of cancelled appointments was high. Appraisal rates for staff were not consistent and required some improvement. We saw good evidence of multidisciplinary working across teams.

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

Evidence-based care and treatment

- We saw evidence that the outpatient clinics used the appropriate national guidance to provide care.

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 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.
- Clinics were regularly cancelled, especially in gynaecology and ophthalmology.
- We reviewed the data received from Lincoln County Hospital around the number of OPD appointments cancelled between October 2013 and March 2014. Data showed that 4.60% of booked outpatient appointments had been cancelled by the provider. However, data did not indicate whether these cancellations were first or follow-up appointments. Trust-wide data showed that, in January 2014, a total of 38,682 patients received OPD appointments. In the same month, the trust cancelled 1,992 patient appointments. In the six month period where the data was available, a total of 223,783 appointments were made, with 10,297 appointments cancelled by the trust in this period. Of the number of cancellations, 7,450 appointments were cancelled within six weeks of the appointment date.

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- On reviewing the endoscopy user's group January minutes, we noted that 164 endoscopy patients were cancelled. Of that number, 50 patients were cancelled by the hospital before the appointment, four patients were cancelled by the hospital on the day and 110 patients cancelled. We saw that two surgical clinics were cancelled, but then covered and four urology clinics were cancelled and then covered. One clinic was cancelled due to a consultant taking annual leave.

Competent staff

- Staff were clear about the roles they undertook within the outpatients department.
- The appraisal rate was 100% in clinics 4, 6 and 9 but in clinic 11 it was 50% and in the preoperative clinic it was 50%. Managers across these areas were given four months in which to meet the 100% target.

Multidisciplinary working

- Multidisciplinary working in OPD was undertaken when referrals were needed for Allied Healthcare professionals, including physiotherapists, occupational therapists and speech and language therapists. For example, referrals were sent to the social work team which is on-site, or to the physiotherapists and occupational therapist, as required. We observed some multidisciplinary working, while at the OPD clinics we observed that referrals had been issued in other cases when reviewing the medical notes.

Seven-day services

Some clinics were available in the evening or on a Saturday morning, but not every speciality could facilitate this, due to the demand on clinic space.

Are outpatients services caring?

Good



The outpatient department was very busy, with patients complaining that clinics were often overbooked. However, patients felt that staff were friendly and did what they could to assist patients. Information was available for patients who felt involved in their care. There was no emotional support available for patients who might receive bad news.

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

Compassionate care

- We spoke to two patients in OPD, who were very complimentary about the staff. They described the staff as "caring, happy to help and supportive". When walking around the hospital with the two OPD sisters, patients' regularly said hello to them and used their first names.
- On the pulse survey conducted in April 2014 across the OPD, we found that, generally, the feedback was positive. Comments about patient care included: "The doctor explained things very well, very impressed," to, "Professional and efficient," and, "Wonderful, professional service given by the nurse practitioner." Others said "very nice and greeted with a smile" and that "staff [were] very helpful and friendly". Another patient said, "One would be pressed to find better health service anywhere, [I] cannot thank the nurses, doctors and all the staff for their kindness."
- The constructive comments included, "Clinic double-booked appointments and I was told to come back later that day," and, "The booking process needed to be looked at, as this was the third appointment at this clinic that had run over." Some mentioned the "small waiting area" which was "not disabled friendly and [the] pharmacy sent my injection to the wrong place".
- We observed reception staff in clinic 1 speaking to patients and relatives in a polite and courteous manner.
- We observed that staff also communicated with patients' relatives effectively and in a kind and compassionate way.
- During the inspection, we saw a very busy clinic 6 (the ear, nose and throat clinic). We spoke to two patients, who told us that the clinic was "always overbooked and we are never seen on time". We were told that they were "never told what was happening and there is never an apology".

Patient understanding and involvement

- We received comments from a patient visiting a clinic, that confidential information had been discussed in the open clinic waiting areas between a staff member and a patient. We did not see this during the inspection.
- In OPD, we found a leaflet called 'your experience counts'. This leaflet outlined how feedback could be given, which included completing the paper leaflet, emailing it to the trust, or by adding comments to the NHS Choices website.

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- Patients we spoke with stated they felt that they had been involved in decisions regarding their care. One parent told us that they felt well-informed in the care plan of their child and was very happy with the care they had received.

Emotional support

- We were told by the clinic sister that there was no protocol for counselling in the OPD. We observed the nurses providing emotional support when needed, to ensure patients were supported after clinic appointments, if required. Patients with a cancer diagnosis were offered emotional support after their holistic needs assessment was undertaken by the clinical nurse specialists.
- There was also no formal counselling service for patients, but they were referred to the chaplain, if needed. The chaplain was multi-faith, and could provide support to patients when they were anxious or upset.

Are outpatients services responsive?

Inadequate



In 2014 we found that the outpatients department was not responsive to the needs of patients. Targets for appointments for patients with cancer were not within the target range, meaning that some patients experienced delays in treatment. Clinics were overbooked and appointments were cancelled. Patients were waiting excessive amounts of time to be seen by medical staff. The department had outgrown its environment, and every available space was used as a clinic room, and this meant that some clinic rooms were almost unfit for purpose.

Patients complained bitterly about waiting times and the new booking system. This system was supposed to ensure that appointments were automatically generated and sent to patients; however, there was little faith in the system, and some patients found that they missed important treatments due to the system.

In 2015 we found that the hospital was continuing to have difficulties with regards to the patient appointment and booking system. This was coupled with the installation and launch of the new patient administration system (PAS), which had caused further problems to the patient booking

system. The hospital did not provide a definitive list, as it was being validated, of patients who were waiting an appointment, or identify those who had been waiting for appointments for extensive periods of time, which could place them at risk of harm. This system therefore had not sufficiently improved and remained inadequate. We reported this to the senior managers at the trust who took action immediately and have supplied an action plan which reflects actions taken. This action plan has provided some reassurance that the trust are managing the issue.

Car parking charges remained a concern during this inspection. Whilst we were told by the executive team that clinics would provide patients with exemption notes for car parking so they would only pay the minimum amount, there was little or no information displayed for this in clinic, and several patients we spoke with were concerned about car parking fees when their clinics were running late.

The hospital had made some improvement with regards to the 2 week cancer waiting time standards; however, the 93% operational standards was still not being met.

Service planning and delivery to meet the needs of local people

- The trust ran a central OPD booking system which opened between 8am and 8pm, called the 'Choose and Book' system (a national electronic referral service, which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic).
- The outpatient department was meeting the cancer two week wait during most of the previous year.
- In 2014 the two week wait symptomatic breast clinic performed poorly over the reporting period, falling outside the operational standard of 93% on 11 months out of 12, with the lowest compliance being in December 2013 (77.1%), and January 2014 (78.4%). In January 2015, the hospital was at a rate of over 80%.
- In 2014 the 62 day standard cancer standard (from urgent GP referral for suspected cancer to first treatment) was not being met in 11 months out of the 12 months in the same reporting period as above. We found that the operational standard of 85% was not being met. In 2015 the trust has continued not to meet the 62 day standard cancer standard of 85% of patients receiving treatment in a timely way. Whilst the trust was not yet meeting this target, improvements were noted, with 75% of patients receiving this treatment.

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- A cancer implementation plan had been put in place by the trust to address the breaches in the standards along the patient pathways. Actions included maximising the appointments available by telephoning patients with appointments to confirm attendance, and the introduction of 'Netcall' software to send reminders to mobiles. The plan was ongoing.
- We reviewed the data on the 18 week targets. As per the latest data for February 2014, the trust saw 92.1% of patients in fewer than 18 weeks from referral to appointment. However, some specialties were not meeting the target and national average. For example, general medicine were only seeing 86.1% of their patients within the 18 weeks, and neurology were only seeing 84.4%.
- In 2015 we found that the 18 week target was being met mostly in some areas, though there had been some impact from Winter pressures. However, the 18 week target was not being met in medicine, trauma and orthopaedics, gynaecology, rheumatology, dermatology and ophthalmology, which meant that further work on capacity and demand was required.
- One patient we spoke to in the community paediatric clinic, told us that the clinic only runs on a Monday morning, and that they should have had an appointment by the end of April, but the first date given was at the beginning of June. This was confirmed by staff we spoke to in the clinic, who told us that the clinic was "very busy" and no cover was given if a doctor was not available to manage the clinic.
- Clinics are overbooked to meet the demand. The sister told us that new patient appointments were allocated 15 minutes, and follow-up appointments were allocated 10 minutes, with some clinics having two doctors to see 30 patients. Delays in the clinics, we were told, would be displayed on the white board in the clinic, when a delay of more than 30 minutes existed. This was not confirmed by patients in the Pulse survey, who commented that they were not kept informed when the clinic was running late.
- In 2015 we reviewed the action plan for outpatients transformation. While some work had commenced the agreed plan for implementing improvement within outpatients was behind trajectory but the pace of implementation was accelerated significantly following the appointment of a dedicated programme manager.
- The service had only completed and recognised the capacity and demand requirements for the hospital, but this did not take place until late 2014. This meant that there had been little or no time prior to our inspection to implement changes identified from the capacity and demand assessment.
- In addition, despite being ordered one week in advance, the availability of records could be an issue. This led to some consultants refusing to see patients without their medical records and cancelling their appointments. A meeting with the health records manager had been held to resolve issues. Clinic managers felt that the situation had improved.
- In 2015 the advanced planning of clinics remained a concern, due to the number of additional clinics being arranged. Services including dermatology and ophthalmology run several additional clinics a week, known as 'short notice' clinics. However, these clinics have occurred every week for long periods of time. There was no rationale as to why these clinics were not worked into the overall business plan for outpatients delivery. We were informed that this was part of the outpatients transformation programme that would be reviewed.
- Staff we spoke to told us that vulnerable patients were fast-tracked, such as those with dementia care needs and anxious patients. If they were inpatients, then they were kept on the ward until their appointment time.
- In 2014 clinics were regularly cancelled, especially in gynaecology and ophthalmology. In 2015 we found that the cancellation rates for clinics remained high, with 31 clinics being cancelled during January 2015 at the Lincoln site alone.
- All clinic cancellations with less than 6 weeks' notice are now authorised by the director of operations or her deputy and cannot be cancelled without valid reasons. It was acknowledged that work was still required around cancellation rates and enforcement of the annual leave policy for clinical staff with regards to their outpatients schedule.
- We reviewed the data received from Lincoln County Hospital around the number of OPD appointments cancelled between October 2013 and March 2014. Data showed that 4.60% of booked outpatient appointments had been cancelled by the provider. However, data did not indicate whether these cancellations were first or follow-up appointments. Trust-wide data showed that, in January 2014, a total of 38,682 patients received OPD appointments. In the same month, the trust cancelled 1,992 patient appointments. In the six month period

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where the data was available, a total of 223,783 appointments were made, with 10,297 appointments cancelled by the trust in this period. Of the whole number of cancellations, 7,450 appointments were cancelled within six weeks of the appointment date.

- Throughout the trust in January 2015, 91 clinics were cancelled across a range of specialities, including endoscopy, gynaecology, rheumatology and ophthalmology. This number remains significantly higher than would be expected almost a year after our previous inspection. The most common reason for cancelling each clinic was the availability of staff and space.
- On reviewing the endoscopy user's group January minutes, we noted that 164 endoscopy patient appointments were cancelled. Of that number, 50 patients were cancelled by the hospital before the appointment, four patients were cancelled by the hospital on the day, and 110 patients cancelled themselves. We saw that two surgical clinics were cancelled, but then covered, and four urology clinics were cancelled and then covered. One clinic was cancelled due to a consultant taking annual leave.

Access and flow

- In 2014 there was an issue for patients concerning the electronic booking system, which booked people into the clinic. The systems booking in terminal was not always placed in the clinic, but in the hallway. We observed that some patients were unsure if they were booked into the correct clinic, and asked the receptionist, thereby defeating the purpose of the electronic booking system.
- We were told by the clinic sister that volunteers were available to support patients at the electronic booking-in terminal.
- In 2015 the service had built and opened a central outpatients reception desk for patients to arrive and check-in, should they have difficulty in using the self check-in system. The desk had been open for one week at the time of our inspection, and was still developing processes for patient flow.
- The main reception desk was only for certain clinics, with dermatology, ophthalmology, rheumatology and gynaecology outpatients having to go to another location to book in for their appointment, which meant that the outpatients arrival process for patients was not yet responsive.
- The hospital operated a partial booking system for follow-up appointments, which meant that if people need an appointment within six weeks of them attending the clinic, this was given to them before they left the hospital. However, if the appointment was for a longer time in the future, then an appointment was sent, in line with the annual leave times of the consultants.
- The partial booking process had been put on Lincoln County Hospital's risk register, as there was a backlog of patients who required clinic appointments (7,500 approximately). The medical records manager told us that the partial booking system was "a good system, it is the lack of capacity in clinics that is causing the back log".
- The concerns around the partial booking system and the outpatient booking system remained, and we were not assured that significant improvements had been made to ensure that the patients in this system were safe.
- The trust had implemented a new patient administration system (PAS), which has further impacted on the partial booking and outpatients system. The introduction of the new system has skewed the data, which meant that the trust did not provide us with a definitive list of how many patients were waiting for an appointment, or that those patients were clinically risk assessed as safe as this was being validated.
- We requested information from the trust to confirm that they were assured that they could identify how many patients were in this system, and that they were assured that all were tracked and on the list to receive an appointment. We did not receive these assurances from the trust; therefore we are not assured that all patients are identified in this system, and the service responsiveness remained inadequate.
- We were informed that in some clinics, audits and assessments were undertaken to ensure that risk profiles on patients were undertaken to minimise risk of harm. We were aware, through examination of the incident records, that in dermatology and in ophthalmology patients had been placed at risk of harm through not receiving their appointment in a timely way.
- The clinic sister told us that because of the partial booking system, patients would be sent their clinic appointments three weeks before their appointment date. Staff told us that the system was not working,

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especially in dermatology and rheumatology, where patients were not receiving follow-up appointments. One patient in rheumatology told us that they had been double-booked, and that they had been told to come back later for their appointment. Another patient had told us that they had not received a follow-up appointment.

- In 2014, as follow-up appointments in some specialities were going over the clinically due date, the business unit was to set out a spreadsheet for short notice clinics. The patient would be phoned, and the medical records requested. We were told that 90% of notes would be obtained, but there was an issue with the filing of results and so on, within the medical records.
- In 2015 we found that the service was now routinely monitoring the availability of notes for clinics and had undertaken regular audits of notes availability. We observed on review of those audits that on average, notes were not available in clinics for 6-19% of occasions. On average, 12% of notes were not available for clinics. This is significantly higher than expected, but the availability of records has improved since 2014.
- In ophthalmology, which was one of the lowest performers for notes availability, we were told by staff that they had seen an improvement in notes availability. They told us that whilst notes were missing in clinics most days, the number of notes missing had reduced.
- From the data in the Pulse survey, the evidence of appointments being changed showed that the present system was not working. The opinions of staff in outpatients and the medical records team differed with regard to whether the system works. Data suggested the system was not working.

Meeting people's individual needs

- In all the clinics we visited, written information was available for patients to take away to read at their leisure.
- The hospital website is a source of information for patients. For example, information around what to expect at the breast clinic was clearly set out for the patient, including: 'what is a mammogram?' and 'will it hurt?' as well as 'what happens next'.
- Appointment letters were clear about appointment times and clinic numbers. However, they also stated

that patients arriving more than 10 minutes late would have their appointments cancelled. However, patients were often waiting far too long in clinics, as they were overbooked.

- A text was sent between 24 and 48 hours before the appointment, as a reminder, to help reduce the number of 'did not attend' appointments. In 2015 we found that the 'did not attend' rate had improved; however, the length of clinic appointment times was increasing, which led to delays for patients receiving their appointment on time.
- Staff we spoke to told us that vulnerable patients were fast-tracked, such as those with dementia care needs, and those who were anxious patients. If they were inpatients, then they were kept on the ward until their appointment time.
- In 2015 we found that the system for booking patients into an appointment slot was not responsive to patient needs. Many clinics were significantly overbooked, which led to lengthy delays for patients awaiting their outpatients appointment. On the Thursday prior to our inspection, in dermatology we observed that the 12.10pm appointment had nine patients booked in to the same appointment slot, with the same consultant. This was not responsive.
- By examining the clinic lists in dermatology, ophthalmology, rheumatology and orthopaedics, we found that clinics were routinely overbooked by double or treble the capacity. This was also confirmed by staff we spoke with, who felt that they had difficulty meeting patient needs when clinics were overbooked.

Learning from complaints and concerns

- Complaints in outpatients were handled appropriately. The matron told us that complaints would be discussed at the matron's meeting on a Wednesday morning and at the ward manager's meeting on the Wednesday evening, as well as with the staff on the next Thursday. Staff said that they hoped that complaints could be resolved locally before the formal complaints process.

Environment

- In 2014 patients told us that there was a lack of parking spaces, and what they felt were unfair charges. The charge for the car park for patients was £1:20 for the first hour, and rising to £3.00 from the second hour. After four hours, there was a further rise. Patients felt this was not fair, because clinics were overcrowded. They were delayed, and then had to pay extra car parking charges.

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- In 2015 we found that concerns raised regarding car parking charges had not improved. On examination of patient information throughout the clinics, we found that there was little or no information displayed for the patients on what would happen to their car parking charges if the clinics over ran.
- We spoke with seven patients and two visitors in clinics that were overrunning during the inspection. All were concerned about how much the car park would cost them, and none were aware that they could ask for a reduced rate if their clinic was running late.
- We spoke with three reception staff about the car parking concerns and late running clinics. All three told us that they did not keep the relevant forms for reduced rate parking at the desk; they had to ask the doctor or nurse to issue them, as they were not authorised to do so. This meant that the car parking concerns for patients had not improved.
- In the paediatric clinic area, there was a children's play area, with toys to keep children happy during their visit. The hospital's clinics were short of space, but they tried to provide toys in other areas.
- In clinic 11 we were told by the matrons that money had been secured, and new chairs and foot stools were to be bought. The trust had given a donation to allow magazines and newspapers to be bought. It was hoped that this initiative would be supported further. Patients told us that they did not mind waiting, as they had magazines and newspapers with which to keep themselves occupied.
- Although the clinic areas are small, we observed that wheelchair users were being supported. In clinic 1 we were told that only one of the clinic rooms could be used for wheelchair users and bed patients. In clinics 3 and 9, wheelchair users could be accommodated in the clinic waiting area.

Are outpatients services well-led?

Inadequate



In 2014 nursing staff felt that their managers were supportive, and knew who to turn to if a problem occurred. However, administrative staff did not support this view. Appraisals were not consistently undertaken in order that staff could develop. Formalised feedback from patients was minimal, and did not contribute to service development.

Staff were aware of the risks within the department, and they took daily action to mitigate these. Senior managers were not addressing the issues raised by patients and staff in respect of the safety and responsiveness of the service.

In 2015 we found that the leadership around outpatients remained inadequate due to the lack of action by the senior management and executive team to resolve the concerns identified at our inspection in 2014 sooner. Locally, improvements were being made to leadership, with the appointment of a matron for outpatients, and staff locally felt that the future of outpatients was positive.

Vision and strategy for this service

- The manager of the department and the matron were able to outline the department's governance procedures. They were also able to tell us how their department performed in all areas.
- Administrative staff we spoke to did not feel supported by their managers. One member of staff told us they did not feel like a valued member of staff and that staff came in when they were off duty, but they wanted to help each other. We were told by a consultant that, "The trust is on one line and the consultants on another line with a big gap in the middle. The whole thing is a mess."
- We were told by the nursing staff that they felt supported by the clinic sisters and the matrons and felt they would get the necessary support, if required. One healthcare assistant told us that, "It's a good team. I feel well supported and know I can go to my sister for support if I have a problem."
- In 2015 we examined the outpatients transformation work and strategy for improving outpatients as a service. Whilst it was positive that this work was being undertaken, this did not commence at pace until October September 2014, long after our inspection ended in May 2014, which did not demonstrate good leadership to improve an inadequate service.
- We spoke with three senior managers about the delay of four months in accelerating the pace of this work to improve the service; all three acknowledged that the delay was unfortunate and more could have been done.

Governance, risk management and quality measurement

- Outpatients held a monthly clinical governance meeting. During the meeting all areas of governance were discussed and reported on, along with any

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learning or changes to the service. The agenda for this meeting included: incident reporting, complaints, training, human resources (HR) management, infection control, risks, health and safety and audit results.

- The OPD used a number of tools to gather the data required to meet with the trust's governance arrangements. Incidents/accidents and near misses were recorded and investigated using the Datix electronic recording system. We found that all of the staff that we spoke with were aware of this reporting system and were using it. The number of Datix incidents and whether they were of a minor, moderate or serious nature were fed up to the trust board.
- The governance report also outlined staff attendance at mandatory training, staff sickness levels, and compliance with the department's audits, such as the hand hygiene audit.

Leadership of service

- The appraisal rate was 100% in clinics 4, 6 and 9, but in clinic 11 it was 50%. In the preoperative clinic it was 50%. Managers across these areas were given four months in which to meet the 100% target. Appraisals needed to be undertaken to secure a skilled, motivated workforce that could meet the needs of the patients.
- The outpatient's service had a new Clinical Nurse Manager (CNM) appointed to oversee outpatients as a service and to clinically drive improvement. Staff were very supportive of the CNM appointment, and felt that improvements would be made under their leadership. However, the CNM had only started in post four weeks prior to our inspection.
- We found that the business unit managers routinely authorised the overbooking of outpatient services. In some outpatient services, including orthopaedics, we found that there was a lack of communication with the staff who organise and set up clinics to facilitate the needs for additional staff and patients. The use of authorisation for the overbooking of clinics did not demonstrate good supportive leadership.

Culture within the service

- All of the staff that we spoke with were able to describe their individual roles. This was backed up by competency assessments of staff that ensured that they both understood and were able to perform their roles to a required standard.
- Throughout our visit, we saw that the department was calm and ordered. Patients told us that staff were both friendly and supportive of them.
- Medical and care staff were aware of the issues they faced within the department but felt that their concerns were not listened to or addressed by the senior managers.

Public and staff engagement

- In 2014 no NHS Friends and Family Tests (FFT) were undertaken in the OPD. In 2015, the OPD had still not launched the outpatients FFT, but there were plans for this to be launched as part of the outpatients transformation programme.
- A patient representative was included in the transformation of outpatients programme, and sat on the internal trust group to improve outpatients by providing a patient's perspective, which was positive.

Innovation, improvement and sustainability

- Matron told us about the 'hot briefs' that take place every Friday morning in clinic 11 (orthopaedics), where the staff discuss five key themes, which may include appraisals, complaints and sepsis bundles to help keep staff informed and up to date with key workings of the department.
- The senior staff within outpatients felt that the clinic was at capacity and that there was no longer any room for expansion, either in the service they offered or in improving services.

Outstanding practice and areas for improvement

Outstanding practice

- Gender separation in the intensive care services.
- People who had complained were invited to take part in recruitment and selection processes for posts in the Patient Advice and Liaison Service (PALS) team.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure that patients receive treatment and care in a timely manner particularly within the outpatients departments.
- Ensure that medical staff review the level of capacity of patients when reviewing resuscitation decisions, to ensure that patients who may lack capacity are protected when these decisions are made about their care.

Action the hospital **SHOULD** take to improve

- Continue improvements to ensure that patient waiting times in outpatients reduce to an acceptable level.
- Review arrangements to ensure that staff undertake mandatory training and appraisals, to ensure that the staff are competent to undertake their roles.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>The provider had failed at times to assess the needs of patients receiving end of life care to ensure their welfare and safety.</p> <p>Regulation 9(1)(a) and (b) (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>Patients receiving end of life care did not always have their mental capacity assessed in order to protect them from inappropriate decisions about their care being made.</p>