

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	Requires improvement	
Medical care	Requires improvement	
Surgery	Requires improvement	
Critical care	Good	
Maternity and family planning	Requires improvement	
Services for children and young people	Requires improvement	
End of life care	Requires improvement	
Outpatients	Inadequate	

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection because United Lincolnshire Hospitals NHS Trust 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, and the unannounced inspection visits took place between 3pm and 10pm on Sunday 11 May 2014.

Overall, 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 outpatient department required urgent improvements to be made to ensure that it was safe and responsive to patients' needs and the leaders of this service are required to improve the service.

Our key findings were as follows:

- Medical records were poor, both in the condition of the records and their availability to outpatient clinics. The confidentiality of medical records in A&E, surgery and outpatients was not always maintained.
- Medication errors were not reported in all areas of the trust.
- There was a lack of junior doctors, which led to night-time junior doctors covering both medicine and surgical wards.
- Infection control practices in A&E and surgery required improvement.
- There was a lack of paediatric nurses in A&E and in paediatric wards.
- Records were not always completed in a timely manner in A&E.
- Mental capacity was not always considered or documented appropriately.
- Delays in discharge were noted across the hospital, with one patient remaining in hospital for three months despite being medically fit for discharge.
- Access to training, both mandatory and training required to undertake the role, was poor.
- Staff appraisal rates across nursing teams were poor.
- Environmental issues in surgery, outpatients and paediatrics required improvement.
- The service for adolescents was poor in the children's and young people's service.
- Outpatients clinics were overbooked and cancellations frequently occurred.
- End of life care for patients, when accessed, was satisfactory. However, there was poor timely referral to the specialist palliative care team and most patients did not die in a place of their choice.
- The hospital had not considered their approach to end of life care following the imminent withdrawal of the Liverpool Care Pathway.
- The outpatients department was crowded, overbooked and waiting times were lengthy.
- The new outpatient appointment booking system was not working.

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.

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 with in surgery and outpatients departments.

Summary of findings

- Ensure that there are sufficient numbers of suitably qualified, skilled and experienced staff in order to meet the needs of all patients at all times in the A&E department, within the paediatric department, palliative care team and in maternity.
- Ensure that there are suitable arrangements in place to protect patients and others against the risks associated with unsafe or unsuitable premises.
- Ensure that suitable arrangements are in place so that all staff are appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users to an appropriate standard. This must be managed through giving staff appropriate training, professional development and supervision.
- Ensure that patients are protected from the risks associated with the unsafe use and management of medicines by means of ensuring appropriate arrangements for the recording and use of medicines are in place.
 - Ensure that patients are protected from the risk of unsafe or inappropriate care or treatment arising from a lack of proper maintenance or availability of an accurate record for each patient.
 - Ensure that patients are protected from infections by appropriate infection prevention and control practices.

We would normally take enforcement action in these instances, however, as the trust is already in special measures we have informed the Trust Development Agency of these breaches, who will make sure they are appropriately addressed and that progress is monitored through the special measures action plan.

In addition the trust should:

- Ensure that records are completed in a timely manner when patients are treated.
- Ensure that patients are discharged in a timely manner.
- Improve services available for adolescent patients and provide a choice for these patients.

On the basis of this inspection, I have recommended that the trust remain in special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Accident and emergency

Requires improvement

Rating



Why have we given this rating?

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, 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 coordinator who managed and kept the patient waiting time to a minimum within this area. We found that immediate observation was delayed and in one case was delayed over two hours.

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 that demonstrated innovation and encouraged learning and listening across all grades of staff. However we saw little impact of the risk planning to address the issues in responsive and safe domains.

Medical care

Requires improvement



Services for medical care were safe 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

Summary of findings

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.

Surgery

Requires improvement



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.

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.

Gaps in staffing were met using bank (overtime) and agency staff, but such staff were not always

Summary of findings

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.

Critical care

Good



Critical care patients received safe, responsive and effective care services. The service was provided in a spacious and clean environment. Admissions to the unit were organised so that they were appropriate and took place without delay. We saw that people received care and treatment according to national guidelines.

The intensive care unit (ICU) was refurbished and uniquely redesigned several years ago to provide single-sex accommodation. The trust set an internal target to avoid breaching the single sex accommodation within ICU and have achieved this, despite it not being a legal requirement. The ICU at Lincoln County Hospital is recorded as the only ICU in England that consistently provides single-sex accommodation to this standard.

There was senior medical expertise available to patients over 24 hours, seven days a week and two consultants were on duty or accessible at all times. One-to-one nursing, or two-to-one nursing, was provided according to each patient's assessed level of need. The staffing ratio was planned so that it was sufficient to meet the needs of critical care patients. Staff training and appraisals were carried out to ensure that staff were competent, aware of best practice, and effective in caring for and treating patients. Care delivered within the unit and to patients on other wards by the outreach team was observed to be person-centred and compassionate. Patients were supported to make decisions about their care where possible, and relatives were included in their family member's care planning. There was effective leadership at all levels within the critical care service.

Summary of findings

Maternity and family planning

Requires improvement



Multidisciplinary team working that supported optimal care for patients was well established. Care was planned and delivered to meet individual needs. Staff were caring and compassionate, patients and relatives spoke highly of the care they had received. The ICU was the base for a critical care outreach team that was able to provide expert advice to help ward staff manage patients whose conditions had deteriorated in both the medical and surgical ward areas. The aim of the team was to prevent further decline, improve patient recovery and reduce mortality.

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.

However, 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 occasion, 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.

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.

Summary of findings

Services for children and young people

Requires improvement



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.

However, improvements were needed. We noted that the service was not staffed in line with current recommendations issued by the Royal College of Nursing and Midwifery (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.

We found that evidence-based care pathways were lacking and that equipment was not always checked appropriately.

Improvements were also 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.

End of life care

Requires improvement



The specialist palliative care team provided positive information and advice to general ward staff on the care of the dying patient. However, 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.

Improvements to the service, in terms of ensuring the overarching strategy was 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.

Outpatients

Inadequate



While patients received good care, the systems to support 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 outside of routine hours. Cancellation of appointments was a

Summary of findings

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.

Requires improvement

Lincoln County HospitalLincoln County Hospital

Detailed findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care; 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.

Our inspection team

Our inspection team was led by:

Chair: Professor Sir Mike Richards, Chief Inspector of Hospitals, CQC

Team Leader: Fiona Allinson, Head of Hospital Inspection, CQC

Of the 33 team members, a team of 16 inspected this hospital. These included CQC inspectors and an analyst, a quality manager, an oral and maxillofacial surgeon, a consultant in emergency medicine, a consultant anaesthetist, and a matron in maternity, a consultant nurse in critical care, a paediatric nurse adviser and an expert by experience.

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.

We held a listening event in Lincoln, at the University, on 29 April 2014, when people shared their views and experiences of the trust. Some people who were unable to attend the listening events shared their experiences via email or telephone.

We carried out an announced inspection visit on 29 April to 2 May 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses,

Detailed findings

administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also 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
- National reporting and learning system (NRLS)
- Deaths 20
- Serious 128
- Moderate 870
- Abuse 42
- **Total 1,060**

Effective:

Detailed findings

- 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	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Outstanding	Good	Good
Maternity and family planning	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	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	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

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, 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.

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 1500 patients a week. During the four-week period from 1st March 2014 to 1st April 2014, the department saw 6135 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 1692. This equated to an admission rate of 27.6%.

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

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, 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 coordinator who managed and kept the patient waiting time to a minimum within this area. We found that immediate observation was delayed and in one case was delayed over two hours.

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 that demonstrated innovation and encouraged learning and listening across all grades of staff. However we saw little impact of the risk planning to address the issues in responsive and safe domains.

Are accident and emergency services safe?

Requires improvement



The A&E department at Lincoln County Hospital requires improvement to ensure that patients are safe. These areas included: infection prevention and control issues, 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.

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, reported regarding events that occurred both internal and external. 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 on incident outcome and closure on incidents they personally reported.
- 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, we observed limited personal protective equipment practice, whereby not all staff were witnessed to be wearing gloves or washing their hands between patients.

Accident and emergency

- 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 *Clostridium difficile* and MRSA infections lay within a statistically acceptable range for the size of the trust.
- During our inspection we noted that there was 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.

Environment and equipment

- The A&E department had recently undergone a refurbishment within some areas, which had improved the reception area, majors and minors treatment areas and the resuscitation area. The ambulatory care service will be relocating once ongoing work is finished.
- The resuscitation area had recently been refurbished and increased in bed space, which came into use on the week of our 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 correct with concise records detailing appropriate daily checks carried out by qualified staff permitted to perform this task.
- 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.

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).

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.

Accident and emergency

Management of deteriorating patients

- 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.
- The A&E department operates a 'track and trigger' alert system 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.
- We observed that the department operates a triage system of patients presenting to the department either by themselves or via ambulance and 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.
- 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.

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. Senior staff acknowledged that they were looking at the RCN 'BEST' policy to understand their staffing needs.
- 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 business case signed off to recruit child-trained nurses and the department was putting in place a training programme to up skill the adult nurses.

- We observed that there was a professional handover of care between each shift.
- All bank and agency staff receive 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.

Accident and emergency

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 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

Accident and emergency

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.

Compassionate care

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

Requires improvement



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 have 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.

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.

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.

Access and flow

- The trust is rated as worse than expected with regards to transition from the ambulance to the A&E department. This is a significant contributing factor that inhibits patient flow and causes consistent ambulance handover delays. The trust has struggled to maintain the 95% target and many times has been below the England average. The lowest was 87.6% in January 2013.

Accident and emergency

- 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. For example: learning disabilities, mental capacity and dementia.
- There was specific equipment to provide the correct care for a bariatric service with privacy and dignity.
- The paediatric service was colocated within the major's treatment area and there was no specific children's waiting area.
- 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 work station 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.
- We noted that a patient already 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.

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.

Are accident and emergency services well-led?

Requires improvement



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.

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.

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.

Accident and emergency

Leadership of service

- There was a strong departmental team, who were respected and led by the senior sister and consultant nurse.
- 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.
- Regular liaison between the three A&E departments in the trust was not in place at the time of our inspection. We were informed that such liaison would be useful in imparting lessons learned from incidents and communicating good practice.

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. The vacancies within the consultant team resulted in an onerous rota, which was potentially unsustainable.







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. For example, a telephone advice service provided to GPs via the ambulatory care service.

Medical care (including older people's care)

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

Information about the service

The acute medical services consisted of 15 wards.

We visited:

- The emergency medical admissions unit (EMAU)
- Burton
- Hatton
- Dixon
- Cardiac short stay
- Stroke unit
- 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.

Summary of findings

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.

Medical care (including older people's care)

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.

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

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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

- Medicines were stored correctly, in locked cupboards or fridges where necessary. Fridge temperatures were monitored.
- Staff administering drugs wore a burgundy tabard to alert other staff, allowing them to avoid unnecessary interruptions.

Medical care (including older people's care)

- There was daily pharmacist support on the wards. All patients' charts were seen by the pharmacist within 24 hours of admission.
- Medication errors were within statistically acceptable limits.
- Monthly controlled drugs audits were being carried out on the medical wards. Action plans were displayed where improvements were required to practice.
- We found one prescription chart, which had not been numbered. Two out of the three charts were still in use. This could have been confusing for staff to follow.

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.

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.

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.

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.

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.

Medical care (including older people's care)

Are medical care services effective?

Requires improvement



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.

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.

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 the SHMI and HMSR data is within expected limits.
- The trust also has a mortality outlier for septicaemia which the trust are preparing a response for at the time of this report. Posters were displayed showing the sepsis pathway to ensure staff were clear of the current guidelines.
- 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.

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.
- 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.

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?

Medical care (including older people's care)

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.

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.

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.
- 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."

Medical care (including older people's care)

- 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.
- 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.

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?

Requires improvement



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.

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.

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.

Medical care (including older people's care)

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.
- Staff felt involved in the 'listening events' where they were encouraged to highlight areas for improvement and possible solutions.

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.

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

We visited six surgery wards, including the Trauma and Orthopaedic (T&O) Wards, the SEAU, 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.

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Summary of findings

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.

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.

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.

Are surgery services safe?

Inadequate



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.

We found that 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 had 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.

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, 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 notice board.
- 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.

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- We identified that 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.
- 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.

Safety thermometer

- The hospital performed worse than the national average for the number of patients with falls with harm, though these data include some falls prior to admission, and catheter or urinary tract infection (UTI).
- 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.

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, 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.
- We saw that there were appropriate systems in place for the cleaning and decontaminating of equipment.
- Isolation procedures were seen to be observed.
- 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.

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.

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- We found that all surgical wards had limited storage capacity, which meant that deliveries and some equipment was stored in corridors or bathrooms.
- Neustadt Welton was a recently refurbished ward. 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.
- During this inspection, 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

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 and Deprivation of Liberty Safeguards was provided to staff. However, 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%.
- 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.

Mandatory training

- Some areas of surgery had higher levels of compliance than others. Staff stated that attendance was dependant on staffing levels. This meant that we were

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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.

- 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

- 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.
- 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.

Nursing staffing

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

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?

Requires improvement



Nationally recognised guidelines and pathways were followed and we found evidence of good multidisciplinary

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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, 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.

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.'

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.

- 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.

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 31day 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

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also showed that 470 cases were identified in the 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.

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.

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.

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.
- 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.

Are surgery services caring?

Requires improvement



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, these 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.

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."

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- 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.
- 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, 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.
- The majority of patients and relatives told us that they felt safe in the hospital. However, we received poor feedback from patients and relatives 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, 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.

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 average, but there was a recovery plan in place to address this. The bed occupancy rates for the hospital were higher than target ranges. 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.

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The surgery service displayed all risks and complaints in an open format on notice boards 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

Service planning and delivery to meet the needs of local people

- 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.
- 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

- The trust was not highlighted as a risk in respect of referral to treatment times for admitted patients.
- Lincoln County Hospital was running a bed occupancy rate of 94% at the time of 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 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.

Meeting people's individual needs

- Inpatient referral to treatment times were within the accepted range at Lincoln County Hospital.
- 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.
- 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 of the opposite gender. The patient told us that they felt embarrassed by this.
- 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.

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- 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 notice boards to show the public what improvements were being made. The action plans for improvement were monitored through the surgical governance and local ward meetings.

Are surgery services well-led?

Requires improvement



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.

However 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.

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.

Governance, risk management and quality measurement

- The surgery directorate held monthly governance meetings, where items and risks were discussed 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.

- 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.

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.
- 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.
- 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

Surgery

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.

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.

Public and staff engagement

- 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.
- On each surgery, ward posters were displayed for 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.

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 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.

Critical care

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

Information about the service

The critical care unit includes an intensive care unit (ICU), which has 20 beds with 16 beds currently commissioned. The service also had five beds in the coronary care unit (CCU). There was no specific high dependency unit (HDU) as this service was included in the ICU provision. The service had planned the commissioning and opening of an additional six-bed HDU, which is expected to open within the next few months.

As part of the inspection, we visited the critical care services and spoke with two patients and two relatives; we were unable to speak with more, due to the clinical status of the patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades, including: nurses, doctors, consultants, physiotherapists and the senior management team. We reviewed performance information about the trust

Summary of findings

Critical care patients received safe, responsive and effective care services. The service was provided in a spacious and clean environment. Admissions to the unit were organised so that they were appropriate and took place without delay. We saw that people received care and treatment according to national guidelines.

The intensive care unit (ICU) was refurbished and uniquely redesigned several years ago to provide single-sex accommodation. The trust set an internal target to avoid breaching the single sex accommodation within ICU and have achieved this, despite it not being a legal requirement. The ICU at Lincoln County Hospital is recorded as the only ICU in England that consistently provides single-sex accommodation to this standard.

There was senior medical expertise available to patients over 24 hours, seven days a week and two consultants were on duty or accessible at all times. One-to-one nursing, or two-to-one nursing, was provided according to each patient's assessed level of need. The staffing ratio was planned so that it was sufficient to meet the needs of critical care patients.

Staff training and appraisals were carried out to ensure that staff were competent, aware of best practice, and effective in caring for and treating patients. Care delivered within the unit and to patients on other wards by the outreach team was observed to be person-centred and compassionate. Patients were

Critical care

supported to make decisions about their care where possible, and relatives were included in their family member's care planning. There was effective leadership at all levels within the critical care service.

Multidisciplinary team working that supported optimal care for patients was well established. Care was planned and delivered to meet individual needs. Staff were caring and compassionate, patients and relatives spoke highly of the care they had received.

The ICU was the base for a critical care outreach team that was able to provide expert advice to help ward staff manage patients whose conditions had deteriorated in both the medical and surgical ward areas. The aim of the team was to prevent further decline, improve patient recovery and reduce mortality.

Are critical care services safe?

Good



The intensive care service was situated in a purpose-built and fully equipped facility. Staff provided care in a mixture of open bays and private side rooms. The service had capacity to open an additional four beds if patient demand required it.

The infection rates on the unit were very low, which showed us that the service had a proactive approach to managing infection and prevention control. Staff assessed people's individual care needs and planned care to meet those needs. Records were complete and comprehensive, so that care could meet the needs of the individual.

There was senior medical expertise available to patients over 24 hours, seven days a week and two consultants were on duty or accessible at all times. One-to-one nursing, or two-to-one nursing, was provided according to each patient's assessed level of need. The staffing ratio was planned so that it was sufficient to meet the needs of critical care patients.

Incidents

- The service was focused on safety. Each member of staff we spoke with confirmed that they knew how to report incidents using the trust's incident reporting system. We examined the incident reporting data for ICU and CCU and found that incidents were reported regularly. A majority resulted in low or no harm being sustained by the patient. The service had not reported any Never Events in the past twelve months.
- We saw records held on the unit of incidents and the minutes of meetings where they had been discussed at multidisciplinary team meetings.
- We noted that the current risks that had been identified at ICU or CCU level were visibly available on a notice board as reminders for staff in the ward areas.
- The service held regular monthly mortality and morbidity meetings, which were chaired by the clinical director for critical care, attended by staff from ICU and CCU. Doctors involved in care were invited to the meetings to present and learn about the process. The minutes of these meetings were made available to us to view prior to the inspection.

Critical care

- We found that the actions and outcomes of these meetings were displayed on the notice board in the ward or department areas for staff to view. Each ward sister we spoke with was aware of the mortality and morbidity reviews for their area and what actions they were taking locally to ensure that risk was reduced. We were reassured that the clinical governance messages and understanding of mortality and morbidity were well thought out and delivered by the clinical leads (both nursing and medical) who knew where the risks were and what actions were being taken to improve patient outcomes.
- We viewed the governance boards displayed in each clinical area, which showed the action plan developed for critical care. This included what action was to be taken in response to the concerns raised by the Keogh Mortality Review. It was evident that while all Keogh Mortality Review actions did not relate to CCU or ICU they had deemed that they could learn to improve from the recommendations given.
- The provider may find it useful to note that during our inspection on ICU we observed a staff member hold on to the hands of a patient who was waking from sedation. The staff member was holding the patient's hands down without speaking with them. This could be seen as a form of restraint. While the rationale behind the decision was to prevent the patient from pulling out their lines, the execution of the technique was inappropriate. This was intercepted by a senior nurse working on the ICU who began to calm the patient by speaking with them. We discussed this with the matron and senior sister who informed us that they would discuss appropriate use of restraint with staff.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care. Locally, we reviewed the information relating to the performance against risk on the ICU and CCU and found that the service was performing better than expected across all parameters. For example, with regards to people who fall, who develop pressure sores, venous thromboembolism (VTE – blood clot in the veins), or those who get catheter urinary tract infections (UTI). The trust displayed their results on a notice board in the wards, which showed their overall performance and areas to be improved upon.

Cleanliness, infection control and hygiene

- Staff wore personal protective equipment, such as gloves and aprons, while delivering care. We also observed staff routinely washing their hands between patients and utilising the alcohol hand rub gel.
- Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- As a safety precaution, and in keeping with infection control good practice, all patients admitted to the hospital were screened for the MRSA and treatment was provided if required.
- The ICU had six side rooms available so that patients with infections or at risk of infection could be isolated while receiving Critical Care. We noted that there were no side room facilities on CCU. However, there were on the neighbouring ward.
- On review of the Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme data, it was evident that both the CCU and ICU had a lower than expected infection rate for infections developed while in the service, which was positive.

Environment and equipment

- The ICU environment had been refurbished within the last few years and the equipment was purchased new at that point. The environment was well maintained, clean and tidy.
- There was sufficient space between each bay, which allowed multiple staff members to work on a patient if needed.
- The CCU was in an older style ward. The CCU had five beds which ensured that the space between each bed was sufficient. We noted that the equipment in some cases was quite dated and was not always appropriate for the care of a CCU patient. For example, some of the beds were not electronic profiling beds, which meant that staff would be required to manually adjust the bed and the patient's position. This could pose a risk to the patient who has an unstable coronary episode.
- The resuscitation equipment had been regularly checked and was fully stocked. Within the CCU, we observed that the resuscitation trolley was restocked and checked after every use. The resuscitation trolley

Critical care

was taken to each bay when care was provided, as staff used items from the trolley to provide care. They also moved the trolley between bays due to the high likelihood of a cardiac episode while care was provided.

- The ICU has dedicated transport equipment available on the unit which would support the transfer of a critical patient to another facility. The equipment was new and met the requirements of the national guidelines and recommendations from the Critical Care Network.

Medicines

- Medicines, including controlled drugs, were safely and securely stored. We examined the medication records of six people during our inspection and found the records to accurately reflect the prescribed and administered medicines for those patients.
- We examined the medication store area in the ICU and CCU and found medicines records and stock to be accurate.
- We examined the controlled drugs book for each area and found that the records accurately reflected the supply. The process for the reviewing and recording of controlled drugs was in line with the Royal Pharmaceutical Society guidelines.

Records

- We reviewed six sets of patient records that contained comprehensive information about patients' assessment and monitoring. We viewed one DNA CPR order in a person's care record. We found that the conversation with the family had been clearly documented and the decisions around why this was needed were fully understood by the family. We spoke with the family about the process of the DNA CPR and what they were told, and found that the records accurately supported what was discussed with the family.
- Patients had well organised individual care files at the end of their beds in ICU and at the nurse base within CCU. We examined clinical reports, risk assessments, care plans, and other records and found them to be fully completed, with appropriate risk assessments in place. There were clear treatment plans that were reviewed on a daily basis.
- The service had commenced the use of the trust's risk assessment and care bundles for sepsis to keep in line with current trust practices. While this was a new development, we observed that it was being undertaken appropriately.

- The records examined confirmed that there was robust risk management for the prevention of patient harms such as blood clots (VTE) and infections through various lines inserted in the patient, including intravenous lines and catheters. There were specific care plans for caring for patients who were unconscious, including mouth care and safe moving and handling. Report entries confirmed that care plans had been followed and the risk reassessed daily

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' treatment was undertaken in line with the trust's policy in obtaining consent to treatment.
- The Mental Capacity Act 2005 was considered appropriately. We examined the records of one patient who had been admitted to the ICU as an emergency. They required emergency medical treatment and while they were in and out of consciousness, staff were unable to gain consent from the person, due to their lack of understanding at that time. Therefore, a mental capacity assessment was appropriately completed to determine the appropriate course of treatment.

Mandatory training

- Staff had access to a comprehensive training programme that included advanced life support, moving and handling, dementia awareness and medication management.
- The training matrix (record) confirmed that over 75% of staff in ICU and CCU had received their mandatory training. The senior sisters were aware of those who had not attended and had arranged for their training to be completed.
- In terms of providing a specialist critical care service we found nurses had completed a significant number of specialist courses and academic qualifications, including: advanced practice in critical care, assessment of the critically ill patient, management in ITU and BSc specialist critical care practice.

Management of deteriorating patients

- The ICU followed an early warning trigger scoring system to monitor deteriorating patients.
- Observations were regularly recorded and the overall staffing levels on the units were sufficient, which meant that deteriorating patient conditions were being managed safely.

Critical care

- Each cardiac arrest or death on the ICU or CCU was investigated by the lead doctor to determine if any lessons could have been learned from the death to improve care.

Nursing staffing

- The nursing establishment within ICU was at a sufficient level. The nursing establishment was based on a recognised staffing assessment tool and met the Royal College of Nursing recommendation of one nurse to each patient assessed at level 3 dependency and one nurse between two patients assessed at level 2 dependency. We examined the staff rotas for ICU and CCU, which supported what we were told.
- The services also utilised Advanced Healthcare Practitioners across critical care to support demand and need for clinical skills, as appropriate. Advanced healthcare practitioners are highly trained clinical staff members.
- In addition, there was a supernumerary sister/matron in charge, a dietician, a pharmacist and an appropriate rehabilitation therapist as part of the multidisciplinary team. In line with these guidelines, patients were admitted to the unit within four hours of a decision being made to admit them. They were continually assessed for rehabilitation and in case they needed escalation to level 3 care.

Medical staffing

- The unit had implemented the recently published guidelines produced by the Intensive Care Society (ICS) that promote the delivery of quality in critical care settings. The unit had followed the guidelines and ensured that it had an on-site lead consultant intensivist, plus a back-up consultant who was available to support if needed. A consultant was available on a 24-hour basis and did not deliver other services during this period, as specified in the ICS guidelines.
- The service had 10 ICU consultants employed, of which nine also practice anaesthesia in theatres. The service was managed by anaesthetics and it provided additional consultant-level support for anaesthetics at times, where consultants are not the dedicated on-call or on-shift consultant for ICU.
- The service accepted junior doctors on rotation, but only in a supernumerary observation role. Trained staff grades were also accepted, but would not partake in on-call rotas. This ensured the safety of the patients.

- Within CCU, the unit was consultant-led and was supported by staff grades, but was at the required staffing establishment for medical staffing in this specialty.

Major incident awareness and training

- The ICU and CCU had a comprehensive business continuity plan that gave details about how patients' care would continue to be provided in an emergency situation, or when each unit's bed capacity was in danger of being overtaken by demand. The unit had an agreed capacity arrangement with the local Critical Care Network it belonged to, so that the unit could respond to patients' needs, ensuring that patients would be cared for. Emergency battery back-up supplies were an integral part of the equipment used; this ensured that vital medicines and life support systems would continue in the event of an electrical power cut or a disruption to the supply of medical gases.
- The unit is part of a Critical Care Network that extends across the East Midlands and the clinical director that supports critical care acted as deputy chair to the Critical Care Network.

Are critical care services effective?

Good



Staff training and appraisals were carried out to ensure that staff were competent, were aware of best practice, and were effective in caring for, and treating, patients. Care delivered within the unit and to patients on other wards by the outreach team, was observed to be person-centred and compassionate. Patients were supported to make decisions about their care where possible, and relatives were included in their family member's care planning.

Multidisciplinary team working was well established and supported optimal care for patients. Care was planned and delivered to meet individual needs. Staff were caring and compassionate, patients and relatives spoke highly of the care they had received.

Evidence-based care and treatment

- Patients to the CCU or ICU were admitted by a consultant on referral arrangement or by a consultant referral to a senior nurse working in the CCU or ICU.

Critical care

During our inspection, we observed a consultant intensivist and consultant surgeon attend the ward with a member of the outreach team to review a patient to determine if ICU admission was required.

- We were informed by a critical outreach nurse and the sister in ICU, that patients were admitted to the unit within a four-hour timescale after it had been decided that they should receive critical care. We reviewed the data on ICNARC, which supported what were told.
- The ICNARC report for activity up to March 2014 showed that 67.9% of patients' admitted to the unit were in need of level 2 care, 26.8% of bed days on the ICU were for patients who required level 3 care (the highest level of care available). Only a minimum number of people required level 1 care.
- The critical care unit also provided aftercare and outpatient appointments. This was in keeping with NICE guidelines about continued support for patients who have suffered a severe trauma or illness that required intensive treatment or life support.
- According to the ICNARC data up to March 2014, of the 91 admissions to ICU reviewed during this period, there were 47 recorded delayed discharges, which was higher than expected for the service. The service was reviewing this data and breaking down the individual reasons for delayed discharges to determine where this could be improved.

Pain relief

- We saw good examples of pain relief being offered to patients on both ICU and CCU. The nurses in charge of the patients' care regularly assessed pain levels and recorded the outcome in the records. We observed that when one patient was in pain, the nurse had escalated this to the consultant, who reviewed the medicines prescribed to ensure the patient was more comfortable.

Nutrition and hydration

- Nutrition and hydration were specifically recorded on charts in both ICU and CCU to monitor intake. Both services undertook malnutrition screening assessments on patients and referred each patient to dietetic services if the patient was identified as being at risk of malnutrition. Staff we spoke with on both units told us that they had a good working relationship with dietetic services and could access their support, if required.

Patient outcomes

- The critical care service participated in the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme reporting system. The ICNARC report up to December 2013 showed that people sometimes experienced a delayed discharge from ICU. This made the service an outlier. We saw that the number of visits by the outreach team and non-outreach team, prior to admission to the unit was greater than the number of unplanned admissions. This indicated that people had been identified for admission to the unit and their care had been planned and anticipated, prior to surgery taking place.
- CQC monitoring of mortality rates and the Hospital Standardised Mortality Ratio (HSMR) for February 2013 to January 2014, as published by the Health and Social Care Information Centre, showed that people were not at increased risk in the ICU or CCU. The ICU and the CCU had generally less than the national average for expected deaths in these areas.
- The trust participated in the National Cardiac Arrest Audit (NCAA), which aims to promote local performance management through the provision of timely, validated comparative data to participating hospitals. It was also notable that, through the use of the observational tools for deteriorating patients, the service had reduced the number of cardiac arrests sustained by patients in these areas to below the expect average for ICU and CCU in England.
- We also determined that the length of stay that most people experienced prior to admission to the unit was one day.
- The CCU provided a specific care service following a heart attack in the community. This was called balloon therapy. This treatment has a high success rate if performed within certain time parameters. Ideally, patients should be seen at the door and door to balloon treatment undertaken within 30 minutes, but the minimum standard is 90 minutes. The trust was achieving 39% of its target. At 30 minutes, the delay was mostly due to the road networks in the county not supporting a timely arrival to hospital. The target for treatment within 90 minutes was over 96%, which meant that the service was achieving above the national average for this service.

Critical care

Competent staff

- We found that the majority of nursing and medical staff across ICU and CCU had received appraisals. Where staff had not received appraisals, or specific training, both the clinical and nurse lead knew the reasons why people had not been updated. For example, one staff member was on maternity leave. There was a clear programme for undertaking appraisals across the critical service and this was well executed by the clinical leads.
- There was a clear scheme for the undertaking of doctor revalidation within critical care. This was led by the clinical director, in conjunction with the medical director. Doctors from surgery who had been identified to go through revalidation were being supported through the process.

Multidisciplinary working

- The unit worked closely with the outreach team who were based on the ICU. The outreach team followed up with patients on the wards post-discharge from ICU or CCU and who were responsible for identifying any patients who might require the support of ICU. All patients transferred out of ICU were followed up using the trust's 'track and trigger' tool to identify any patients who may be deteriorating.
- There were two consultant-led ward rounds daily; members of the multidisciplinary team joined these rounds to provide specific expert advice. For example, we were told that anaesthetists, surgeons or the microbiologist could join the rounds, if required.

Seven-day services

- We saw good communication by staff working within the unit. We observed the outreach team working closely with staff in other wards. We observed wards contacting the critical care outreach team whenever they identified a patient who was likely to have deteriorating and critical care needs. We saw that other healthcare professionals were involved in patients' critical care plans. Physiotherapists, speech and language therapists, dieticians and pharmacists were involved in the multidisciplinary approach that ensured the wellbeing of the patient.
- Allied Healthcare professionals were to commence seven-day-working from 1 May 2014. This included pharmacy, occupational therapy and physiotherapy. However, it was identified that they were to do this on with the current staff in place. We also found that there were no immediate recruitment plans to recruit new

Allied Healthcare professionals into posts to support a seven day service. 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 critical care.

Are critical care services caring?

Good



Care delivered within the ICU and CCU to patients on other wards by the outreach team was observed to be person-centred and compassionate. We saw that patients were treated with the utmost respect and dignity throughout their treatment. We saw that nurses were attentive and were always in very close proximity to patients and spoke to them after introducing themselves.

Patients were supported to make decisions about their care where possible, and relatives were included in their family member's care planning. The ICU provided appointments for patients to follow up with them directly regarding any concerns that they may have had following discharge from the unit. This appointment also includes emotional and wellbeing support for the patient and family.

Compassionate care

- Care delivered within the ICU and CCU to patients on other wards by the outreach team was observed to be person-centred and compassionate. We saw that patients were treated with the utmost respect and dignity throughout their treatment. We saw that nurses were attentive and were always in very close proximity to patients, introducing themselves after speaking to them.
- We noted that curtains were used to ensure privacy and that patient dignity was maintained.
- We spoke with two relatives during our inspection and both told us they had been treated with consideration and kindness by nurses, doctors and consultants. They told us they had spoken to the consultants and had also been telephoned by them and by nursing staff to keep them informed about their family members' progress. One relative told us, "They are so kind and attentive here, [I] cannot fault them. The care has been excellent." A second relative told us, "The staff can't do enough for you, they are wonderful."

Critical care

- We examined the NHS Friends and Family Test results for the ICU and CCU prior to our inspection and we found that, overall, feedback about ICU and CCU was positive and people were happy with their experience of care within the service.

Patient understanding and involvement

- Patients were supported to make decisions about their care where possible, and relatives were included in their family member's care planning. Staff we spoke with explained how they expected patients to be able to make decisions about their care whenever possible and they supported patients in this process. Relatives we spoke with told us they had been kept fully informed about their family members' care and treatment.

Emotional support

- There are quiet rooms for the sole use of relatives to discuss sensitive issues in privacy. There was an overnight facility for relatives on the unit, should any relative wish to stay overnight and be near their family member. This meant that the service recognised and understood the emotional needs of the family and provided facilities to support their need.
- The trust did not have a dedicated bereavement service, however, bereavement support was offered through the ICU and CCU 24-hours a day, seven days a week. Staff provided support and guidance to the family. Access to specialist nurses was also available to support the emotional needs of patients and families.
- Patients from all critical care areas could access the multi-faith chaplaincy services for support. Information on how to access chaplaincy services was available through staff. Staff told us they regularly interacted with the trust's palliative (end of life care) team, who provide support and advice during bereavement.

Are critical care services responsive?

Outstanding



The ICU operated a single-sex accommodation protocol, with the ICU being divided into two separate areas of eight beds and two side rooms. This meant that service were responsive to patient needs by designing and implementing a critical care model that ensured that single-sex accommodation could be consistently achieved. Lincoln County Hospital is the only recorded hospital to

operate a single-sex accommodation scheme of this scale in England. We saw evidence of this in minutes of meetings of the Critical Care Network and through our review of journals and NHS websites.

Access to a critical care bed on ICU or CCU bed was an available resource for patients considered suitable for critical care. There were no reported instances of a critical care bed not being available. The bed occupancy recorded on ICNARC for the period up to March 2014 showed an occupancy rate of 77%.

Service planning and delivery to meet the needs of local people

- There were plans in place to meet patients' critical care needs in the event of the unit reaching capacity through an arrangement with the local Critical Care Network that Lincoln County Hospital is part of.
- The service provided a retrieval service for patients who were from Lincolnshire, but were in intensive care elsewhere. The retrieval process meant that a team from the critical care team at Lincoln County Hospital would travel by ambulance to the hospital where the patient was located and safely transport them back to the critical care facilities at Lincoln County Hospital. This meant that families could be nearer patients for visiting.
- The service is linked to the Critical Care network covering East Midlands. This meant that the hospital was actively involved in the planning and decision-making process around critical care services in the area, to ensure that patient needs for critical care at Lincoln were met.

Access and flow

- Access to a critical care bed on ICU or CCU bed was an available resource for patients considered suitable for critical care. There were no reported instances of a critical care bed not being available. The bed occupancy recorded on ICNARC for the period up to March 2014 showed an occupancy rate of 77%, which meant that services in critical care were accessible to patients, if required.
- Patients were discharged from the ICU to the general ward areas. However, on occasion, these were delayed discharges, due to bed availability within the hospital. This was a recognised risk for the hospital and there was an action plan in place to address ongoing concerns with hospital occupancy.

Critical care

- Admission and discharge from critical care was carried out in accordance with agreed policies and protocols that were clearly understood by medical staff. When the service had reached capacity, the service had the capacity to open additional beds on ICU and utilise spaces in theatre recovery as well.

Meeting people's individual needs

- The critical care outreach team provided a response 24-hours a day, seven days a week to patients who were identified in other wards as potentially in need of critical care. The team assisted with the management of these patients in other wards when their physical health was identified as deteriorating, or if they were considered to be in need of critical care on admission.
- The ICU provided appointments for patients to follow up with them directly regarding any concerns that they may have, following discharge from the unit. This appointment also included emotional and wellbeing support for the patient and family.
- The ICU operated a single-sex accommodation protocol with the ICU being divided into two separate areas of eight beds and two side rooms each. This meant that service was responsive to patient needs by designing and implementing a critical care model that ensured that single sex accommodation could be consistently achieved. While it is not a legal requirement for a critical care area to have single-sex accommodation, Lincoln County Hospital is the only recorded hospital to operate a single-sex accommodation scheme of this scale in England. We viewed the data for single-sex breaches recorded on the trust's internal target measure and found that the service had successfully maintained single-sex accommodation for over twelve months.

Learning from complaints and concerns

- We found that the service had received few complaints overall and that, according to the NHS Friends and Family Test were mostly happy. The frequent concerns raised by patients who stayed on CCU were around the noise from machine alarms. We spoke with the sister and matron about this, who said it was difficult to resolve this concern because the unit is a coronary care service and there were often alarms sounding around changes to a person's condition. We noted that the service was aware of the issue and swiftly responded to alarms to support people, but also so as not to disturb other patients.

Are critical care services well-led?

Good



We found that the clinical leads for both nursing and medical staff in the critical care service demonstrated clear leadership. The service operated at fast pace, but maintained excellent patient outcomes with lower than expected levels of mortality and harm across all measurable levels.

We observed that the culture within the service was open and that staff at senior level, including the clinical director and matron, were approachable. Staff we spoke with were supportive of the leadership within the service and felt the culture was open and that they were listened to.

Vision and strategy for this service

- We saw evidence that the matron was visibly leading the ICU and CCU, together with the senior sister for each area, all of whom were dedicated to meeting their service's needs.
- The senior clinicians for ICU and CCU we spoke with had a good understanding of the performance of their department and had a sound knowledge of the analyses of the electronic data that supported this understanding.
- The senior clinician for CCU and ICU told us how they had a vision for the CCU, ICU and critical care as a whole to be seen as a leading service in critical care.

Governance, risk management and quality measurement

- We found that incidents were analysed by senior clinical staff, the matron and appropriate consultant specialist. Staff told us that they received feedback from the incidents they reported, both individually and in ward meetings, which supported what we were told.
- All staff had been involved in monitoring the quality of the unit and staff we spoke with were willing to implement changes in order to make continuous improvements. Weekly team meetings and multidisciplinary meetings ensured that staff were kept well informed and involved in change and that they could openly discuss the service and clinical care matters.

Critical care

Leadership of service

- The service operated a critical care development programme for staff nurses employed by the trust. This meant that band 5 nurses could rotate into the critical care service to become trained critical care nurses.
- It was felt by staff that there was an open culture to quality and improvement and a positive attitude to auditing and monitoring the progress and activity of the service that was provided by the unit.
- We saw that changes required to trust-wide practice were communicated to staff by updated displays on the notice boards in staff areas or on a one-to-one basis if required. The staff we spoke to were aware of the notice board and were required to regularly review the information displayed on it.

Culture within the service

- Nursing staff told us that the matron for critical care and senior sisters in ICU and CCU were very approachable and supportive. We were informed by medical staff working on ICU and CCU that the clinical lead and consultants were very approachable and supportive and willing to educate trainees.
- During our inspection and time on ICU and CCU, we saw that staff on the units readily approached the matron or the senior sisters for advice and information to ensure patient treatment and care were maintained and effective at all times.

- We were informed that the matron was open to suggestions for improvement and that there was an open culture to change across the critical care service. A student nurse also commented that it was a strong team and everyone worked well together.
- We observed a junior grade doctor approach a consultant during our inspection to ask about the care plan for a patient and how best to understand their treatment decisions. We observed that the consultant was keen to demonstrate clinical decision-making skills to the trainee and nurse present.







Public and staff engagement

- The public at the time of elective surgery were not offered a visit to the ICU to show them the ward area prior to their admission for elective surgery. The offer to visit the ICU may benefit some patients and reduce stress or anxiety around admissions.

Innovation, improvement and sustainability

- The ICU was the implementation of a new six-bed HDU area for level 1 patients, which will be built next to ICU. This plan was accepted by the trust board and work to upgrade the ward area to a level 1 HDU attached to the ICU was to be completed within a few months. This will enable forward-planning for capacity of level 2 and 3 patients and will provide an additional six bed spaces. While the service maintained good capacity levels through winter, the service was planning for the future, with higher hospital attendance rates requiring critical care support expected.

Maternity and family planning

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

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

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.

However, 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 occasion, 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.

While there were good systems of governance in place, we found that staff had not identified key risks and

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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.

Are maternity and family planning services safe?

Requires improvement



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 unsafe. 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 this service is working safely.

Incidents

- As part of this 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.

Maternity and family planning

- 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 1960s and there were challenges in relation to the set-up of the environment. At the time of this 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 their being asbestos within the building, remedial action could not take place swiftly.
- 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

- We saw that separate areas were used for the storage of medications and these were secured appropriately.
- We spoke to people using this service who confirmed that they been spoken with about the medications being given to them.

Records

- 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 inspection, there was no named midwife for safeguarding. They had recently left the trust and recruitment was ongoing.
- However, all staff spoken with were clear that there was a central safeguarding contact for the trust who they could contact in the interim if there were any concerns.
- 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

- 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.
- We reviewed mandatory training statistics which showed in March 2014 only 35% of staff on Bardney Ward had completed their mandatory training. Similarly, only 38% of staff on Nettleham Ward had completed the same.

Management of deteriorating patients

- There were clear processes in place to deal with the deteriorating patient. 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.

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.
- 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 (mothers and babies needing an extra level of support) team 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 addition, should Bardney Ward have needed assistance, their first escalation route was to utilise the midwives on shift on Nettleham Ward. While staff were called in to cover when Bardney Ward needed assistance, there was still a risk that emergencies and ongoing care needs on Nettleham Ward may not have been dealt with safely, due to an inadequate amount of staff on shift.
- Concerns were also raised 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 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. Senior members of staff told us that there were plans in place for an additional midwife to be present on this unit in the future.
- A recruitment exercise had been completed and eight whole time equivalent midwives had been recruited. However, at the time of our inspection, the service was not staffed for a midwife to birth ratio which met national guidance. The Royal College of Obstetrics and Gynaecology (RCOG) recommend a ratio of one midwife to every 28 births. Lincoln County Hospital was working to a ratio of one midwife to 30 births.
- We also found that community midwives were not staffed in line with national recommendations. In some

instances the ratios were significantly higher than the recommended level of one midwife to every 100 patients. The example of current ratio's given to us included one to 124 and one to 158.

Medical staffing

- We found that medical staffing was in line with the RCOG's recommendations. This amounted to 60 hours of consultant cover per week and a lead obstetric anaesthetist.
- Many of the staff spoken with 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.

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?

Requires improvement



The service had good processes in place to make sure 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.

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.

Maternity and family planning

- 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.
- The service was not meeting national recommendations in relation to the amount of supervisors of midwives

(SoM) that it had in place. Recommendations state that one supervisor should be in place for every 15 midwives. Although recruitment had been ongoing at the time of our inspection, the service reported that one SoM was available for every 16/17 midwives.

- It was confirmed that all midwives had met with their supervisor for their annual supervisory meeting last year.
- However, every member of staff we spoke with, with the exception of the obstetric clinical lead, told us that they had not received an appraisal or work-based supervision in the previous year.
- Some staff members, particularly those in support positions, reported to us that they felt undervalued.

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.
- 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.

Compassionate care

- Women were enabled to maintain their privacy and dignity. While on the Bardney Ward, we noted that all

Maternity and family planning

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.

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.

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.

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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?

Requires improvement



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.

Vision and strategy for this service

- There was uncertainty between the staff groups about what the vision for the service was. We asked a number of staff who could not give a clear answer.

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.
- 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. For example, 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.
- 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.
- There was confusion with some staff about how performance information was shared. We were told that a newsletter was produced on a monthly basis. However, some staff spoken with were not aware of this.

Maternity and family planning

Leadership of service

- 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.
- However, there was no head of midwifery in place during our inspection; this post was due to be filled in June 2014.
- 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 told us that morale within the service was still quite low, but there had been improvements.

- 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 to make the service sustainable and give patients a better experience. At the time of our inspection the trust had not made a decision on whether or not the business case should be accepted.

Services for children and young people

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

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.

During the inspection, 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.

Summary of findings

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.

However, improvements were needed. We noted that the service was not staffed in line with current recommendations issued by the Royal College of Nursing and Midwifery (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.

We found that evidence-based care pathways were lacking and that equipment was not always checked appropriately.

Improvements were also 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.

Services for children and young people

Are services for children and young people safe?

Requires improvement



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, there was 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.

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.

Environment and equipment

- 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.

- 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.
- 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

- We reviewed training records provided and found that not all staff had taken part in training as deemed mandatory by the trust.
- In relation to safeguarding training, only 16 out of the 43 members of staff (whose electronic records we reviewed), had received this training.
- Nine out of 43 members of staff had completed infection control training.
- Eight out of 43 members of staff 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,

Services for children and young people

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

- At the time of our inspection, Rainforest Ward was not staffed in line with national guidance, as recommended by the Royal College of Nursing. 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.
- 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 a high dependency service. However, on occasion, if the staff were unable to have patients transferred 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.
- 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

- 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

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.

- The service was finding recruitment of medical grade staff difficult. This meant that there was regular use of locums within the service.

Major incident awareness and training

- 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.
- 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?

Requires improvement



The service had good processes in place to make sure 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.

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.

Services for children and young people

- 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.
- However, 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 the service was not providing the most effective care to the children it was looking after.>

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.
- At the time of our inspection, 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.

Competent staff

- There was no clinical supervision programme in place.
- We found that only 60% of staff had received an appraisal within the last year.
- 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.

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

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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 to 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 to 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?

Requires improvement



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.

Service planning and delivery to meet the needs of local people

- During our inspection of theatres we observed that the paediatric recovery area was used by theatre staff to support both adults and children in the same area. We saw that there was no partition or separation between the adult and paediatric area.
- 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.
- However, 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.
- While staff told us that every effort would be made to keep older and younger children in different areas, 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.
- The service was also not in line with current guidance in relation the number of isolation beds it needed.

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.

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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.
- However, 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 is provided by the local mental health trust.
- 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.
- However, the environment on the NICU Ward needed improving. There was a noticeable lack of wall art and the areas seen were clinical and forbidding.

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?

Requires improvement



The leadership of the service required some improvement in order that patients were kept safe, 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.

Whilst leaders were visible and supportive of staff the lack of staff, mandatory training rates and pathways for children need 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 the service faced.

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.
- 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.
- 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.

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- 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.
- Issues such as staffing, attendance at mandatory training and the development of the service through care pathways was not being comprehensively addressed by the local management.







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.

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

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 visit 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, 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.

Improvements to the service, in terms of ensuring the overarching strategy was 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.

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Are end of life care services safe?

Requires Improvement



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.

Incidents

- 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.
- 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 register 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.
- 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".

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.
- 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.
- Following the Keogh Mortality Review, the trust was told to redesign the form. The DNA CPR form in use at the

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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 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.
- We found only two wards which had completed the DNA CPR forms correctly.
- 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 they would take this issue to a meeting that afternoon.
- 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 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.
- 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.
- 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'.

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

Mandatory training

- 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.
- The palliative care consultant 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.

Assessing and responding to patient risk

- The SPC team told us 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.
- We were told by the SPC team that medical teams often found it hard to 'back up decisions'. At that point, the medical teams would refer to the SPC team, where discussions took place with the patients and families. Interventions would be stopped and the patient would receive supportive care.
- We saw no evidence of advanced care plans on the end of life patients' medical records we reviewed. This was

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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.

- Following referral, patients referred to the SPC team on end of life care were reassessed on a regular basis, to ensure 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, 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.
- On the Waddington Ward, 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).

Medical staffing

- There was one palliative care consultant across the hospital.

Are end of life care services effective?

Requires Improvement



During our inspection, 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.

Evidence-based care and treatment

- We spoke to the SPC team, who 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 has to 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.

- 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 Lincoln County Hospital did not achieve the key performance indicators in five of the seven indicators.

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Pain relief

- Symptoms were managed following the Liverpool Care Pathway Symptom Control Guidelines. The palliative consultant will visit the ward twice a week and will advise on symptom management. The families will be kept informed of any changes in the condition or management of their relative. We observed that discussions were written in the medical records.

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.

Competent staff

- We were told by the palliative care team, that all extra training is on hold across the trust. 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.
- The SPC Clinical Nurse Specialists (CNS) were supported by McMillian Cancer Care, where they could attend McMillian teaching days, as well as being given financial support to attend other outside courses. Clinical supervision was received through McMillian Cancer Care.
- 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.
- 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 (for example, 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 and 9am to 5pm. Families could ask the ward staff to see the team.
- 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

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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.

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 this with 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

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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?

Requires Improvement



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.

Service planning and delivery to meet the needs of local people

- 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.
- 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 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. We were told by the SPC team, referrals are approximately 80% 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 neuron 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 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. 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

End of life care

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.

- 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.
- There was a fast track discharge process which was not responsive to the wishes of the patient as it took an average discharge times of between one and seven days.

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 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?

Requires Improvement



While the trust executives and the local hospital could describe plans for this service. These were yet to be implemented and staff were not aware of these plans. 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 have been.

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.
- 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,

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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 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 said to be appointed to develop the service. This would be a shared role with St Barnabas Hospice.
- 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 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.
- 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 this had recently been put up on the ward.

Culture within the service

- We found little evidence of palliative care involvement in the hospitals work programme. The SPC team were not included in the development or discussions of trust policy. For example, 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.
- 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.
- We found little evidence on the wards that staff had received end of life care training.







Public and staff engagement

- We found little evidence of public or staff engagement in end of life service development.

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.

Outpatients

Safe	Inadequate	
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, 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.

Summary of findings

While patients received good care, the systems to support 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.

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Are outpatients services safe?

Inadequate



Whilst there had been low reporting of incident within the outpatient department the systems and process 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.

Incidents

- The outpatients department had not reported any Never Events in the previous year.
- The department had a low rate of reporting incidents; however, this is not uncommon in this type of department.
- 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 hospitals 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

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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 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.

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.
- 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

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. We checked two forms and saw that these were not filled in correctly, as two professionals had not completed the form.

- The Mental Capacity Act 2005 guidance clearly states that people must be assumed to have capacity unless proven otherwise. However, on the form there was minimal space to clearly document the patient's decision.
- 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.
- 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

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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.

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.

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.
- 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.

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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.

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.
- 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



The outpatient 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

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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.

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.
- However, the two week wait symptomatic breast clinic performed poorly over the reporting period, falling outside the operational target of 93% on 11 months out of 12, with the lowest compliance being in December 2013 (77.1%) and January 2014 (78.4%).
- The 62-day standard cancer target (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.
- 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 was only seeing 84.4%.
- 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 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 the situation had improved.
- Staff we spoke to told us 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.

Access and flow

- 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 are 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.
- 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 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

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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 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, 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 they had not received a follow-up appointment.
- As follow-up appointments in some specialities were going over the clinically due date, the business unit was to send 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.
- From the data in the pulse survey, the evidence of appointments being changed was evidence 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 to 48 hours before the appointment, as a reminder to help reduce the number of ‘did not attend’ appointments.

- 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.

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

- Patients told us that there was a lack of parking space and what they see as unfair charges. The charge for the car park for patients was £1:20 for the first hour and then this rose 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.
- 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 they did not mind waiting, as they had magazines and newspapers to keep themselves organised.
- 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



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

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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 to the safety and responsiveness of the service.

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."

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 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.

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

- Notices were displayed at the entrance to outpatients, inviting staff and patients to give feedback to the leadership team about the services they received.
- No NHS Friends and Family Tests were undertaken in the OPD.

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

- The intensive care unit was the only unit in Britain to have separate male and female accommodation. This is due to the design of the unit and affords patients greater privacy and dignity when requiring a higher level of care.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure that patients receive treatment and care in a timely manner particularly with in surgery and outpatients departments.
- Ensure that there are sufficient numbers of suitably qualified, skilled and experienced staff in order to meet the needs of all patients at all times in the A&E department, within the paediatric department, palliative care team and in maternity.
- Ensure that there are suitable arrangements in place to protect patients and others against the risks associated with unsafe or unsuitable premises.
- Ensure that suitable arrangements are in place so that all staff are appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users to an appropriate standard. This must be managed through giving staff appropriate training, professional development and supervision.
- Ensure that patients are protected from the risks associated with the unsafe use and management of medicines by means of ensuring appropriate arrangements for the recording and use of medicines are in place.
 - Ensure that patients are protected from the risk of unsafe or inappropriate care or treatment arising from a lack of proper maintenance or availability of an accurate record for each patient.

- Ensure that patients are protected from infections by appropriate infection prevention and control practices.

Action the hospital **SHOULD** take to improve

- The trust should ensure that records regarding the timely observations and pre-alert forms are completed in a timely manner when patients are treated in A&E.
- The trust should ensure that patients are discharged in a timely manner across all wards and in particular, at the end of their life.
- Improve services available for adolescent patients on the paediatric wards and provide a choice for these patients.
- Improve treatment for bariatric patients, by ensuring they are involved in choices about their care and ensure that their dignity and independence is respected.
- Improve the monitoring of bowel care effectively across the trust.
- The trust should ensure that outpatient clinics are not overbooked and cancellations minimised.
- The trust should ensure that a patient's mental capacity is always considered and documented appropriately.
- The trust should work with the community to ensure that DNA CPR forms are recognised and acted upon in the community.