

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



Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Requires improvement



Surgery

Good



Maternity and gynaecology

Requires improvement



Services for children and young people

Good



Outpatients and diagnostic imaging

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

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

We inspected Lincoln County Hospital between the 10-14, 18-19 and 26-27 October 2016. We also carried out unannounced inspections on 24, 25 and 27 October 2016.

We included the following locations as part of the inspection:

- Lincoln County Hospital
- Pilgrim Hospital
- Grantham Hospital

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

We rated Lincoln County Hospital as requires improvement overall. Surgery and services for children and young people were rated as good, urgent and emergency care, medical care and maternity and gynaecology were rated as requires improvement.

Our key findings were as follows:

Safe

- There were not always effective systems in place to ensure ambulance handover times took place in line with the Department of Health target of 15 minutes, with no patients waiting more than 30 minutes and that the initial assessment of patients should take place within 15 minutes of presentation to the department.
- Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of harm because they did not receive the correct treatment in a timely manner and in line with national and local guidelines.
- Staff did not routinely raise patient safety incidents for those patients who had not been appropriately screened or treated for sepsis.
- In some areas, staff did not always recognise concerns, incidents or near misses. Where incidents had been raised some staff reported little or no feedback and could not give examples of where learning from incidents had taken place.
- Safety systems, processes and standard operating procedures were not always fit for purpose. We saw out of date resuscitation equipment and insufficient evidence to suggest resuscitation equipment had been checked in line with trust policy. Arrangements were not always in place to ensure the safe storage of medicines and arrangements for the disposal and storage of used sharps meant there was a risk of harm to staff, patients or members of the public.
- Records to demonstrate hourly rounding (checks on patients) were not always completed.
- There was no abduction of children policy available for any of the inpatient areas of the service.
- Health records were not always available for outpatient appointments.
- As of the week of our inspection, there were 8,108 patient appointment outcomes, which staff had not completed and closed on the electronic record system. Data supplied by the trust showed the current position was worse than the previous year. This presented a risk to patients in their ongoing treatment and care. Following our inspection the trust had forecast that the numbers of incomplete outcomes would fall by half in early 2017.
- Nurse staffing on the neonatal unit was in line with the British Association of Perinatal Medicine (BAPM) standards.
- Patients were protected from abuse; staff had an understanding of how to protect patients from abuse. Staff could describe what safeguarding was and the process to refer concerns.

Summary of findings

- Staff used paediatric early warning scores (PEWS) and neonatal early warning scores (NEWS) to appropriately identify a deteriorating patient.

Effective

- The trust's Hospital Standardised Mortality Ratio (HSMR) for March 2016 was 97.62. HSMRs are intended as an overall measure of deaths in hospital. High ratios of greater than 100 may suggest potential problems with quality of care.
- The latest published Summary Hospital level Mortality Indicator (SHMI) for January 2015 to December 2015 was 110.99 and within hospital SHMI deaths was a reported 105.4 for the same period. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.
- Patient's care and treatment was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to the National Institute for Health and Care Excellence (NICE) quality standards. However, staff did not consistently adhere to local guidelines for sepsis screening.
- Where outcomes for patients were below expectations when compared with similar services we saw action plans had been put in place.
- Nursing staff were not always managed or developed effectively. Not all nursing staff had received an annual appraisal and appraisal completion rates had significantly declined since the previous year.
- Endoscopy services at this hospital were Joint Advisory Group (JAG) accredited.
- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient care and treatment; with involvement from general nurses, medical staff, allied health professionals (AHPs) and specialist nurses. All staff we spoke with told us there were good lines of communication and working relationships between the different disciplines.
- Staff had some understanding of the Mental Capacity Act (MCA) 2005 and consent. We saw consent to care and treatment was mostly obtained in line with legislation and guidance, including the MCA and patients were supported to make decisions.

Caring

- Generally, feedback from patients who used the service and those close to them was mostly positive about the way they had been treated.
- We observed nursing and medical staff treating patients with dignity, respect and kindness. Staff spent time talking to patients and showed compassion when patients needed help. However, at times, staff focused on the task instead of the patients as individuals. Staff were providing one to one support for some patients as they had been assessed as being at increased risk. However, when providing one to one support, staff did not always engage with patients meaningfully.
- Results of the CQC A&E Survey (2014) showed the trust performing 'about the same' as other trusts.
- The NHS Friends and Family Test (FFT) results were worse than the England average.

Responsive

- There were systems in place to support vulnerable patients and those patients who were medically fit for discharge, with good access to learning disability specialist nurses and the assertive in-reach team (AIR).
- Some patients were not able to access services for assessment, diagnosis or treatment when they needed to.

Summary of findings

- Patients had been unable to access services in a timely way for an initial assessment, diagnosis or treatment including when cancer was suspected. During 2016 the trust has failed to meet the majority of the national standards for the cancer referral to treatment targets. This included the referral standard for patients suspected of cancer who needed to be seen with two weeks. This standard had not been consistently met during 2016.
- The trust had failed to meet the national standard for the referral to treatment time for incomplete pathways for the previous three consecutive months.
- There were significant delays in patients receiving their follow up outpatient appointment across several specialities with 3,772 appointments being overdue by more than six weeks. These did not include the patients identified as missing from the waiting lists.
- Stroke services provided timely access to initial assessment, diagnosis or urgent treatment of those patients who may be experiencing a stroke.
- Delays in obtaining to take out (TTO) prescriptions had been identified as delaying discharges and staff attributed this in part to a sporadic pharmacy service to the wards. In addition, pharmacy staff did not routinely access the electronic discharge documents and this resulted in discrepancies not being identified until medicines had been dispensed.
- There was insufficient consideration paid to meeting the information and communication needs of patients. The service had not taken steps to meet the requirements of the accessible information standard. However, staff could access interpreting services for patients who did not speak or understand English. The service was provided externally and included the provision of British Sign Language.

Well led

- Generally staff knew there were a vision and strategy in place for the trust.
- There was not always an effective governance framework which supported the delivery of safe, good quality care.
- We found some risks regarding the provision of services for patients had not been identified by senior nurses and service leads.
- We were not assured incidents were reported and acted upon appropriately. Staff did not routinely raise patient safety incidents for those patients who had not been appropriately screened or treated for sepsis. This meant there were missed opportunities to address poor compliance in order to minimise the risk of patients being exposed to avoidable harm, when they met the trust criteria for sepsis screening.
- Staff satisfaction and morale varied across the hospital with some staff groups feeling more engaged than others.
- We found most staff were dedicated and committed to delivering high quality, safe care.

We saw several areas of outstanding practice including:

- The emergency department (ED) inputted hourly data into a specific risk tool which had been created, to give an internal escalation level within ED separate to the site operational escalation level. This tool gave an “at a glance” look at the number of patients in ED, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building and there were local actions for easing pressure.
- The ED had designed and were using a discharge tool ‘TRACKS’ (T-transport, R-relatives/ residential home, A-attire, C-cannula, K-keys, S-safe) to facilitate the safe discharge of older and/or vulnerable patients.
- The trust had introduced a carer’s badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carer’s badge encouraged carer involvement, particularly for patients with additional needs. Being signed up to the carer’s badge also gave carers free parking whilst they were in attendance at the hospital.
- Ashby Ward had just introduced visits from pets called a therapy (PAT) dog. PAT is a charity and volunteers from PAT, along with their own pets, visit care organisations to enable patients to interact with them.

Summary of findings

- On the care of the elderly wards a red, amber, green system was used to identify patients who required more assistance than others. Red signified those patients who required the most help, whilst green identified those patients who required the least. This system was also applied to each patient's menu card to signify the amount of support a patient required with eating. Patients with a green sticker were given their meals first. Staff who took meals to patients with a red sticker then stayed to support the patient to eat their meal.
- Staff on Nocton Ward had introduced sibling activity bags for any siblings of the infants admitted on the ward. This demonstrated a positive approach to involving the whole of the family in the service experience.

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

Importantly, the trust must:

- The trust must take action to ensure staff in the emergency department are appropriately trained and supported to provide the care and support needed by patients at risk of self-harm.
- The trust must take action to ensure all staff working in the emergency department receive appropriate supervision, appraisal and training to enable them to fulfil the requirements of their role.
- The trust must take action to ensure systems and processes are effective in identifying where safety is being compromised and in responding appropriately and without delay. Specifically, systems and processes to identify and respond to the assessment and treatment of sepsis in the emergency department.
- The trust must take action to ensure staff have the appropriate qualifications, competence, skills and experience, in addition to paediatric life support, to care for and treat children safely in the emergency department.
- The trust must continue to ensure systems and processes are effective and that staff respond appropriately in recognising and treating patients in line with the trust's sepsis six care bundle.
- The trust must take action to ensure ligature risk assessments are undertaken and that ligature cutters are available in all required areas.
- The trust must take action to ensure staff in maternity are appropriately trained and supported to provide recovery care for patient's post operatively.
- The trust must take action to ensure all staff working in the termination of pregnancy service receive formal counselling training.
- The trust must take action to ensure that the handover process on Nettleham Ward does not compromise patient's privacy.
- The trust must take action to ensure that sensitive patient groups are not mixed within gynaecology and maternity outpatient areas.
- The trust must ensure the environment within Clinic 6 is reviewed and actions taken to prevent or control the potential risk to patients from infections. The trust must comply with the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance.
- The trust must ensure that the drinking water dispensers are cleaned and maintained in accordance the manufacturer's instructions including completion of scheduled electrical safety testing, a water hygiene maintenance programme and cleaning schedule.
- The trust must ensure that equipment is appropriately maintained. It must ensure any checks carried out by staff are recorded and done with sufficient frequency and with sufficient knowledge to minimise the risk of potential harm to patients.
- The trust must ensure that patients who are referred to the trust have their referrals reviewed in a timely manner to assess the degree of urgency of the referral.
- The trust must ensure that the patients who require follow up appointments are placed on the waiting list.

In addition the trust should:

- The trust should ensure there are effective and consistent systems for learning from incidents to be shared across the emergency department.

Summary of findings

- The trust should ensure the governance framework in the emergency department clearly identifies risks, responsibilities and actions required to ensure all staff raise patient safety incidents appropriately.
- The trust should ensure that the resuscitation trolleys and their equipment are checked, properly maintained and fit for purpose in the emergency department.
- The trust should ensure there are adequate processes in place to ensure handovers between the ambulance and the emergency department take place within 15 minutes with no patients waiting more than 30 minutes.
- The trust should ensure there are adequate processes in place to ensure patients who self-present to the emergency department receive an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival.
- The trust should ensure that there is 16 hours of consultant presence available each day in the emergency department.
- The trust should ensure there are appropriate procedures in place for identifying seriously ill patients who self-present at the reception of the emergency department.
- The trust should ensure procedures are followed regarding the safe management of sharps boxes.
- The trust should ensure all staff have completed mandatory and role specific training.
- The trust should ensure the environment for children's provision in the emergency department meets the 2012 Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings.
- The trust should ensure staff are appropriately trained and supported to meet the requirements related to duty of candour.
- The trust should ensure an annual audit is carried out in line with the recommendations of The Royal College of Emergency Medicine (RCEM) guidelines; Management of Pain in Children (revised July 2013).
- The trust should ensure they take steps to address the accessible information standard in the reception area of the emergency department at Lincoln County Hospital.
- The trust should ensure mandatory training is completed in line with trust policy.
- The trust should ensure all staff are aware of the arrangements in place to respond to major incidents.
- The trust should ensure hourly rounding charts and charts used for monitoring fluid balance of patients are completed to ensure the health, safety and welfare of the service users.
- The trust should ensure medications are always handled safely, in line with legislation, the trust's policies and best practice guidelines.
- The trust should ensure venous thromboembolism treatment is prescribed in a timely manner and re-assessed after 24 hours.
- The trust should ensure there are measures in place to ensure patient medical notes are stored securely.
- The trust should ensure continued engagement within the Oromaxillo facial service in order to further develop the service.
- The trust should consider 24 hour reception cover on the surgical emergency assessment unit.
- The trust should consider a discharge co-ordinator post within ward areas.
- The trust should consider how the role of the domestic assistants support the ward team in relation to food serving and cleaning.
- The trust should ensure that grading of incidents is consistent and follows trust guidance.
- The trust should ensure that the new IT system supports accurate documentation of safety thermometer data.
- The trust should ensure that notes for patients undergoing caesarean section are consistent including standardised documents.
- The trust should ensure that safeguarding supervision is provided regularly for all staff.
- The trust should ensure that accurate up to date maternal weights are performed on admission in order to prescribe weight dependant medication.
- The trust should ensure that the resuscitation trolleys on Bardney Ward are checked, and appropriate documentation completed.

Summary of findings

- The trust should ensure that if recent NICE guidance is not followed then the current guidance includes an addendum to explain the decision (CG 190).
- The trust should ensure staff development programmes are supported and staff are encouraged to attend learning opportunities.
- The trust should audit the length of time patients attending for emergency gynaecology appointments are expected to wait.
- The trust should ensure that within maternity service users feedback is captured.
- The trust should ensure that they audit the number of patients whose elective caesarean sections are delayed to the next day.
- The trust should ensure that action plans are made following audits, and a re-audit is performed, such as following the regular CTG audits.
- The trust should ensure outpatient and diagnostic services are delivered in line with national targets.
- The trust should ensure that incidents are correctly graded and there are effective systems in place to ensure learning from incidents takes place.
- The trust should ensure that there are sufficient documented procedures and records in place to provide assurance that ultrasound probes are decontaminated after use in line with the manufacturer's recommendations and in compliance with the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance.
- The trust should ensure that there is sufficient signage throughout the outpatient department to direct patients/visitors to the hand hygiene facilities that are provided to minimise the risk of spreading infection.
- The trust should ensure that the condition of health records enables the safe care and treatment of patients, compliance with information governance requirements and ensures patient confidentiality is maintained.
- The trust should ensure all staff working in the outpatient and diagnostic departments attend the trust's mandatory training programme as required by their role and professional responsibilities.
- The trust should consider reviewing the method by which MRI reports are transferred onto the Radiology Information System to ensure the risk of error during the transfer of data is minimised or removed.
- The trust should ensure that there are sufficient systems in place and utilised to minimise the risk of potential harm to patients. Sufficient time must be available to ensure comprehensive patient identity and procedure checks are completed prior to all diagnostic procedures being commenced.
- The trust should ensure that staff working in the radiology department have sufficient knowledge of the national diagnostic reference levels to be able to apply them appropriately when required.
- The trust should take action to ensure all staff working in the outpatient and diagnostic services receive an annual appraisal to ensure they are able to fulfil the requirements of their role.
- The trust should consider whether the action taken to reduce the back log of clinic letters waiting to be sent to GPs and patients following their appointment was effectively resolving the backlog of letters.

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

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

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

We were not assured incidents were reported and acted upon appropriately. Staff did not routinely raise patient safety incidents for those patients who had not been appropriately screened or treated for sepsis. This meant there were missed opportunities to address poor compliance in order to minimise the risk of patients being exposed to avoidable harm, when they met the trust criteria for sepsis screening. Where incidents had been raised some staff reported little or no feedback and could not give examples of where learning from incidents had taken place. Following our inspection the trust told us staff had been trained in risk reporting but they did not always recognise concerns, incidents or near misses. Staff reported little feedback from incidents but the trust told us they had several systems for sharing lessons learnt. We did not see this on inspection.

Staff did not consistently adhere to local guidelines for sepsis screening and the trust had a higher than expected hospital standardised mortality ratio (HSMR) in the area of sepsis. Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of harm because they did not receive the correct treatment in a timely manner. There was not an effective governance framework in place to support the delivery of safe, good quality care. Significant risks regarding the provision of services for patients had not been identified by senior nurses and service leads. Risks identified during the inspection such as insufficient numbers of paediatric nurses working in the department and the environment for children and young people had not been assessed or placed on the department risk register.

The environment and staffing arrangements in the emergency department (ED) did not meet Intercollegiate Committee Standards for Children

Summary of findings

and Young People in Emergency Care Settings (2012). In the children's waiting area there was no audio-visual separation from the adults' waiting area and limited numbers of age-appropriate games. Not all nursing staff had been trained to care for children. However, there were cubicles both in the resuscitation and major's area of the department dedicated to the care of children and young people.

Safety systems, processes and standard operating procedures were not always fit for purpose. We saw out of date resuscitation equipment and insufficient evidence to suggest resuscitation equipment had been checked in line with trust policy. Arrangements in place to ensure the safe storage of medicines and disposal and storage of used sharps had not been adhered to. This meant there was a risk of harm to staff, patients or members of the public.

Nursing staff were not always managed or developed effectively through the appraisal process. Not all staff had received up to date mandatory training and staff had not received training regarding their responsibilities in line with legislation and guidance, including the Mental Health Act (1983). There was no policy or procedure for the administration of the Mental Health Act (1983; amended 2007) or the assessment, management and care of adult patients who attended the emergency department (ED) due to self-harming or suicidal behaviours.

Royal College of Emergency Medicine (RCEM) audit results showed outcomes for patients were sometimes below expectations and the ED performance for ambulance handover times, the number of patients being treated, admitted or discharged in under four hours, the initial assessment of patients taking place within 15 minutes of presentation to the department and trolley waits were worse than national standards and Department of Health targets.

Medical staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times. There were low levels of staff satisfaction in addition to high levels of stress and work overload.

Summary of findings

There was insufficient consideration paid to meeting the needs of those patients who were hard of hearing and staff we spoke with were not aware of a dementia care pathway and 'action cards' available for those patients living with dementia. The care provided to patients in urgent and emergency services was good. Patients were supported, treated with dignity and respect and were involved as partners in their care. It was easy for patients to complain or raise a concern. Posters and leaflets were available in the ED and these allowed members of the public to identify how they could raise a concern or make a formal complaint. Patient's care and treatment was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to the National Institute for Health and Care Excellence (NICE) quality standards. Individual care records were written and managed in a way that kept people safe. Records were accurate, complete, legible and stored securely.

The service had been proactive in addressing significant concerns we had identified during our inspection concerning ligature points in the department and the department's ability to respond to an emergency or major incident. Responses were timely and appropriate and actions had been put in place to assess and manage risks to patients.

There was effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff were qualified and had the skills they needed to carry out their roles effectively including being appropriately trained and proactive in their approach to safeguarding. Medical and nursing staff were dedicated and committed to delivering high quality, safe care. At times of extreme pressure we saw staff united in managing the flow of attendances through the department.

Services were planned with commissioners, other providers and relevant stakeholders and delivered in a way that met the needs of the local population with an assessment and ambulatory care unit (AAC)

Summary of findings

located next to the ED that provided urgent, same day treatment for patients, so that they did not have to be admitted to hospital if there was no requirement for this.

Medical care (including older people's care)

Requires improvement



Surgery

Good



We rated this service as good because:

Staff understood their responsibilities to raise concerns and report incidents and near misses. Lessons were learned and communicated widely to support improvement. For example, thorough checking of surgical hip or lens implants before use. Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies.

Monitoring and audit of safety systems was robust. There was an effective audit for the World Health Organisation (WHO) five steps to safer surgery checklists.

There were systems, processes and standard operating procedures in infection prevention control, records, and maintenance of equipment, which were mostly reliable and appropriate to keep patients safe.

Patients were protected from abuse; staff had an understanding of how to protect patients from abuse.

Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation and patients received effective care and treatment. We saw where patients symptoms of pain were mostly managed in both ward and department areas with good comfort outcomes.

We observed staff positively interacting with patients and patients were treated with kindness, dignity, respect and compassion while they received care and treatment. Feedback from patients was positive about the care and treatment they had received.

Summary of findings

Surgical care services were responsive to patient's needs; patients could access services in a way and at a time that suited them and there was a proactive approach to understanding and meeting the needs of individual patients and their families. The leadership, governance and culture in surgical care services supported the delivery of high quality person-centred care; governance and risk management arrangements were mostly effective and as such able to protect patients from avoidable harm.

There were periods of inappropriate skill mix when staffing the escalation beds in the surgical assessment lounge.

There was a lack of consistency in staff understanding of the Mental Capacity Act (2005), the use of mental capacity assessments and Deprivation of Liberty Safeguards (DoLS).

Medical staff in the head and neck clinical directorate were not always compliant with the trust appraisal process.

Maternity and gynaecology

Requires improvement



We rated this service as requires improvement because:

The grading of incidents was not always consistent. Collection of data was also inconsistent across the service.

Staff did not demonstrate learning from audits such as CTG audits or post-partum haemorrhage audits. The maternity dashboard data was not utilised fully. The data lacked red amber and green rating, which meant that staff could not assess the data against trust targets.

Staff did not receive regular recovery training.

Only 51% of health care assistants had received training in basic life support.

Patient confidentiality could be compromised by the location of staff handover on Nettleham Ward. There was no midwife led unit, reducing patient's choice for a home from home environment.

Sensitive patient groups were mixed within the gynae-oncology clinic and antenatal clinic.

The lack of a dedicated elective caesarean section operating teams meant that in the event of an emergency patient's surgery would be delayed.

Summary of findings

Governance structures functioned effectively and interacted appropriately. Teamwork throughout the hospital was apparent and staff felt they were listened to.

A strong business unit team had increased the visibility of the patient's and children business unit in the last 18 months.

When something went wrong staff told us people received a sincere apology. Openness and transparency was encouraged. Staff were aware of their responsibilities for reporting incidents, and learning was shared.

Medicines were stored safely with clean secure preparation areas. Clinical areas were clean and staff had made efforts to improve the environment for patients.

Patients care and treatment was planned and delivered in line with current evidence-based guidance. Normal birth rates and still birth rates were better than the national average. A seven day antenatal maternity day assessment service was available for patients with concerns or high risk pregnancies.

Staff were caring and compassionate in the care they provided. The service had increased the number of trust wide specialist midwives. Some of these such as the bereavement midwife had not started.

Patients and families knew how to raise a concern and were treated compassionately when they did.

Services for children and young people

Good



We rated this service as good because:

There was a good understanding of the incident reporting system with most incidents reported being of the no harm to low harm category. The service had not reported any never events in the 12 months prior to the inspection.

There were good infection prevention and control measures within the service and this was reflected in the zero cases of healthcare acquired infections.

The use of the paediatric early warning score (PEWS) and neonatal early warning score (NEWS) was embedded within the service and aided timely recognition of the deteriorating patient.

Summary of findings

The service delivered care according to local and national policies which were evidence based, and also contributed to national audits to benchmark care against other providers.

We observed many positive examples of compassionate and dignified care being provided to all patients. Feedback from parents, carers and the children themselves was complimentary about the care they had received and felt the level of information provided was adequate. They were also complimentary about the involvement of siblings in the patient experience and how staff extended the compassionate care to them.

The service was responsive and met the needs of the children and young people accessing the service. The hospital had engaged with local parent groups about service planning and delivery and also provided facilities for parents to stay with their child whilst admitted.

The service was well-led at local ward/unit level and staff told us and we found the leadership above this level was also good.

Nurse and medical staffing did not meet requirements of the Royal College of Nursing (RCN) and Royal College for Paediatric and Child Health (RCPCH). Nurse staffing on the children's ward did not have an experienced member of staff on for each 24 hour period and did not provide at least one member of staff with advanced paediatric life support (APLS) or European paediatric life support (EPLS) qualification on each shift. There were insufficient members of the medical team to provide paediatric consultant cover seven days per week. In addition consultant cover provided did not cover the busy 12 hour period up to 10pm.

There was a lack of awareness on the children's ward in relation to ligature risks, for example we did not see a ligature risk assessment had been carried out and there were no ligature cutters immediately available in the ward area. There was no abduction policy; therefore we were not assured that all staff would know what actions to take in the eventuality of a missing child.

We could not be assured that sepsis management was embedded within the service and this was supported by information provided by the trust.

Summary of findings

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

Outpatients and diagnostic imaging

Requires improvement



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

The concerns we found during this inspection were the same as our findings in 2014 and 2015, this was despite actions plans to address the areas of concern following both of these inspections.

We saw significant numbers of patients overdue for appointments including new and follow up appointments. Performance against some cancer waiting targets was consistently below the national standards placing patients at risk of potential harm from delayed treatment. Where the trust made progress to address the backlog of waiting list appointments this negatively affected the trust meeting the referral to treatment standards for new patients across many specialities.

Data showed 8,108 patient appointment outcome records, which had not been completed and closed on the electronic record system. Data supplied by the trust showed the current position was worse than the previous year.

The trust had not maintained an accurate record of patients who required outpatient appointments. The trust was tracking thousands of computer records to establish the patients who should have received appointments.

There were delays of up to several months in the reporting of some diagnostic reports due to failures in the information technology systems used by the regional picture archiving and communication system (PACS).

Progress against some poor performance and identified risks was slow. We saw issues identified since our last inspection had not been addressed for example, overbooking of clinics. Reports showed there had been long standing issues for example, condition of health records, which the trust had not addressed.

There was a potential risk to patient safety because managers did not always share learning from

Summary of findings

incidents with all staff. Safety procedures and maintenance contracts were not always in place to ensure the environment and equipment were adequately assessed, risks identified and equipment maintained.

Nursing staff were not always managed effectively as not all staff had received up to date mandatory training. Medical staffing vacancies affected the trust's ability to meet the demand for outpatient services.

The condition of patient health recording had a negative impact across all clinic areas and posed a potential risk to patient confidentiality. The lack of availability of records affected most clinic areas. Staff provided patients with evidenced based care and treatment and followed national guidelines. Patients received care delivered by staff that were experienced, skilled and had knowledge to deliver care that met patient's needs.

Staff in outpatient and diagnostic services provided a caring, professional and compassionate service. Staff ensured patients received the best possible care. Patients were happy with the care they received. Staff had been flexible and worked their weekends to provide additional clinics in many specialities to try to meet the demand for outpatient services.

Diagnostic radiology services delivered care and treatment in a safe environment. Systems were in place to protect patients from harm during radiological investigations and ensured compliance with the departments legal responsibilities.

Lincoln County Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology; Services for children and young people; Outpatients and Diagnostic imaging;

Detailed findings

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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. Through three main hospitals and four sites, the trust provides a range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services to the 700,000 people of Lincolnshire. The trust employs 7,478 staff and has three main hospitals: Pilgrim Hospital in Boston (391 beds), Grantham and District Hospital (110 beds) and Lincoln County Hospital (602 beds). The trust also provides services at County Hospital Louth, John Coupland Hospital in Gainsborough, Skegness and District General Hospital and the Johnson Community Hospital in Spalding.

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

outpatient services. The A&E department provides care for specific emergency situations within the wider population, for example, ear, nose and throat (ENT), gastro intestinal bleeds, primary percutaneous coronary intervention and stroke.

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

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

Our inspection team

Our inspection team was led by:

Chair: Judy Gillow.

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

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

Detailed findings

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

How we carried out this inspection

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

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

Before our inspection, we reviewed a wide range of information about United Lincolnshire Hospitals NHS Trust and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, National

Health Service Intelligence (NHSI), Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team. We also spoke with patients and members of the public as part of our inspection.

The announced inspection took place between the 10-14, 18-19 and 26-27 October 2016. We held focus groups with a range of staff throughout the trust, including, nurses, midwives, junior and middle grade doctors, consultants, administrative and clerical staff, physiotherapists and occupational therapists, porters and ancillary staff. We also spoke with staff individually.

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

Facts and data about Lincoln County Hospital

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

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

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

Staff Group

WTE (Staff in post)

Establishment

Medical Staff

792.69

928.11

Nursing and Midwifery Staff

1925.79

2208.09

Allied Health Professionals

350.67

394.26

Other Clinical Staff

1497.92

1379.52

Other Non-Clinical Staff

1874.22

2037.16

Any other staff

4.80

Detailed findings

2.00

Total Staff

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

In 2015/16 the trust had:

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

Our ratings for this hospital







Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

Urgent and emergency services are provided by United Lincolnshire Hospitals NHS Trust at three sites across Lincolnshire: Lincoln County Hospital; Pilgrim Hospital Boston and Grantham and District Hospital. The trust primarily serves a population of over 720,000 people, situated in the county of Lincolnshire. It is one of the largest acute hospital trusts in England.

The emergency department based at Lincoln County Hospital provides consultant-led emergency care and treatment 24 hours a day, seven days a week to people across Lincoln and the North Lincolnshire area.

The department has 15 'major' and three 'minor' cubicles, a four-bedded resuscitation room, an eye treatment room, two triage rooms, a plaster room, designated waiting rooms for adults and paediatrics and a quiet/relatives room.

There are two beds and a flexible number of seats on the assessment and ambulatory care unit (AAC). The AAC provides urgent, same day treatment for patients, so that they do not have to be admitted to hospital if there is no requirement for this. AAC is open daily from 8am to 10.30pm.

In the reporting period September 2015 to August 2016, 71,345 patients attended the emergency department at Lincoln County Hospital; 12,631 (18%) of these were children.

During our inspection of urgent and emergency care services we visited all areas of the emergency department

and AAC. We spoke with 12 patients, five relatives and 57 staff. We spoke with staff including junior and senior medical staff, junior and senior nursing staff, advanced care practitioners (ACPs), emergency nurse practitioners (ENPs), matrons, support workers, receptionists, house keepers, medical locum staff, paramedics from a local NHS ambulance trust, private ambulance staff, the mental health liaison team from a local NHS trust, a volunteer and senior staff in the trust including service leads.

As part of our inspection we used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us. We observed interactions between patients, their relatives and staff, considered the environment and looked at 21 adult and 13 paediatric patient care records, 10 medicine administration charts and 16 patient observation/sepsis screening pathway records. Following our inspection, we reviewed performance information from and about the trust including information from 12 comment cards completed by patients and relatives before our inspection.

Urgent and emergency services

Summary of findings

We rated urgent & emergency services as requires improvement overall.

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

- We were not assured incidents were reported and acted upon appropriately. Staff did not routinely raise patient safety incidents for those patients who had not been appropriately screened or treated for sepsis. This meant there were missed opportunities to address poor compliance in order to minimise the risk of patients being exposed to avoidable harm, when they met the trust criteria for sepsis screening. Where incidents had been raised some staff reported little or no feedback and could not give examples of where learning from incidents had taken place. Following our inspection the trust told us staff had been trained in risk reporting but they did not always recognise concerns, incidents or near misses. Staff reported little feedback from incidents but the trust told us they had several systems for sharing lessons learnt. We did not see this on inspection.
- Staff did not consistently adhere to local guidelines for sepsis screening. Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of harm because they did not receive the correct treatment in a timely manner.
- There was not an effective governance framework in place to support the delivery of safe, good quality care. Significant risks regarding the provision of services for patients had not been identified by senior nurses and service leads. Risks identified during the inspection such as insufficient numbers of paediatric nurses working in the department and the environment for children and young people had not been assessed or placed on the department risk register.
- The environment and staffing arrangements in the emergency department (ED) did not meet Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings (2012). In the children's waiting area there was no audio-visual separation from the adult's waiting area and limited numbers of age-appropriate games. Not all nursing staff had been trained to care for children. However, there were cubicles both in the resuscitation and major's area of the department dedicated to the care of children and young people.
- Safety systems, processes and standard operating procedures were not always fit for purpose. We saw out of date resuscitation equipment and insufficient evidence to suggest resuscitation equipment had been checked in line with trust policy. Arrangements in place to ensure the safe storage of medicines and disposal and storage of used sharps had not been adhered to. This meant there was a risk of harm to staff, patients or members of the public.
- Nursing staff were not always managed or developed effectively through the appraisal process. Not all staff had received up to date mandatory training and staff had not received training regarding their responsibilities in line with legislation and guidance, including the Mental Health Act (1983). There was no policy or procedure for the administration of the Mental Health Act (1983; amended 2007) or the assessment, management and care of adult patients who attended the emergency department (ED) due to self-harming or suicidal behaviours.
- Royal College of Emergency Medicine (RCEM) audit results showed outcomes for patients were sometimes below expectations and the ED performance for ambulance handover times, the number of patients being treated, admitted or discharged in under four hours, the initial assessment of patients taking place within 15 minutes of presentation to the department and trolley waits were worse than national standards and Department of Health targets.
- Medical staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times. There were low levels of staff satisfaction in addition to high levels of stress and work overload.
- There was insufficient consideration paid to meeting the needs of those patients who were hard of hearing and staff we spoke with were not aware of a dementia care pathway and 'action cards' available for those patients living with dementia.

Urgent and emergency services

However, we also found:

- The care provided to patients in urgent and emergency services was good. Patients were supported, treated with dignity and respect and were involved as partners in their care. It was easy for patients to complain or raise a concern. Posters and leaflets were available in the ED and these allowed members of the public to identify how they could raise a concern or make a formal complaint.
- Patient's care and treatment was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to the National Institute for Health and Care Excellence (NICE) quality standards. Individual care records were written and managed in a way that kept people safe. Records were accurate, complete, legible and stored securely.
- The service had been proactive in addressing significant concerns we had identified during our inspection concerning ligature points in the department and the department's ability to respond to an emergency or major incident. Responses were timely and appropriate and actions had been put in place to assess and manage risks to patients.
- There was effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff were qualified and had the skills they needed to carry out their roles effectively including being appropriately trained and proactive in their approach to safeguarding. Medical and nursing staff were dedicated and committed to delivering high quality, safe care. At times of extreme pressure we saw staff united in managing the flow of attendances through the department.
- Services were planned with commissioners, other providers and relevant stakeholders and delivered in a way that met the needs of the local population with an assessment and ambulatory care unit (AAC) located next to the ED that provided urgent, same day treatment for patients, so that they did not have to be admitted to hospital if there was no requirement for this.

Are urgent and emergency services safe?

Inadequate



We rated urgent and emergency services as inadequate because patients were not protected from avoidable harm.

We found:

- There were not effective systems in place to ensure ambulance handover times took place in line with the Department of Health target of 15 minutes with no patients waiting more than 30 minutes and that the initial assessment of patients should take place within 15 minutes of presentation to the department.
- Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of harm because they did not receive the correct treatment in a timely manner and in line with national and local guidelines.
- Staff did not routinely raise patient safety incidents for those patients who had not been appropriately screened or treated for sepsis.
- Staff did not always recognise concerns, incidents or near misses. Where incidents had been raised some staff reported little or no feedback and could not give examples of where learning from incidents had taken place.
- Cleanliness, infection control and hygiene was not always given sufficient priority. Between September 2015 and August 2016, environmental cleaning audit results were consistently below the trust target of 95% for each month.
- The environment and staffing arrangements in the emergency department (ED) did not meet Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings (2012). In the children's waiting area there was no audio-visual separation from the adult's waiting area or access to quieter waiting and treatment areas, and age-appropriate games. There were no cubicles dedicated to the care of children and young people and not all nursing staff had received the required training to care for children.
- Safety systems, processes and standard operating procedures were not always fit for purpose. We saw out

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of date resuscitation equipment and insufficient evidence to suggest resuscitation equipment had been checked in line with trust policy. Arrangements in place to ensure the safe storage of medicines and disposal and storage of used sharps had not been adhered to. This meant there was a risk of harm to staff, patients or members of the public.

- Not all staff had received up to date mandatory training in all safety systems with completion rates for staff in the ED significantly below the trust target across a number of subject areas.
- Medical staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times.

However, we also found:

- The service had been proactive in addressing significant concerns we had identified during our inspection concerning ligature points in the department and the department's ability to respond to an emergency or major incident. Responses were timely and appropriate and actions had been put in place to assess and manage risks to patients.
- Individual care records were written and managed in a way that kept people safe. Records were accurate, complete, legible and stored securely.
- Safeguarding of vulnerable adults, children and young people was given sufficient priority. Staff were appropriately trained, proactive in their approach to safeguarding and were focussed on early identification.

Incidents

- There had been no never events in urgent and emergency services between August 2015 and July 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Between March 2016 and June 2016 the trust reported seven serious incidents in urgent and emergency services. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or

organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Of these, two occurred in the emergency department (ED) at Lincoln County Hospital. One resulted in the death of a patient and one resulted in 'severe harm'.

- Urgent and emergency services reported 93 incidents at Lincoln County Hospital between March 2016 and June 2016. Of these 75 were categorised as 'no harm', 11 'low harm', five 'moderate', one 'severe' and one 'death'. The most frequently reported incident categories related to clinical care (27), medicines (16), slips/trips/falls (5) and aggression/violence (5).
- An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff. Incidents, accidents and near misses were reported through the trust's electronic reporting system and staff told us they understood their responsibilities to raise concerns and to record safety incidents and near misses.
- We were not assured all staff were raising patient safety incidents appropriately. Staff did not routinely raise patient safety incidents for those patients who had not been appropriately screened or treated for sepsis (a potentially life-threatening condition triggered by an infection or injury) and one member of staff told us they felt verbal abuse to staff was under reported. When we returned to the trust, unannounced, 11 working days following our initial inspection the ED sister told us there had been discussions with staff regarding raising incidents and staff were now expected to raise a patient safety incident for those patients who had not been appropriately screened or treated for sepsis. We saw where discussions had taken place and the sister showed us three incidents relating to sepsis.
- Incident investigations, action plans and identified learning points were discussed during the ED 'daily brief'. Minutes we reviewed demonstrated where immediate actions taken following the departments recent serious incident had been discussed. However, six members of staff told us they did not always receive feedback from incidents they had raised. Staff could not give any examples of changes in practice that had resulted from incidents. We were therefore not assured there was a robust system in place to learn from all incidents.
- Mortality and morbidity (M&M) meetings were held monthly as part of the ED clinical governance

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meetings. The meetings had representation from the ED including consultants, junior doctors, a matron, nurse consultant, advanced care practitioners (ACPs) and a quality and safety officer. Mortality and morbidity meetings allowed staff representatives from the ED the opportunity to review and discuss individual cases to determine if there could be any shared learning.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Nursing and medical staff we spoke with had a limited understanding of the duty of candour process but were able to describe duty of candour as being open and honest if something had gone wrong. Most staff felt they did this as part of their day to day work. None of the nursing or medical staff we spoke with had received any formal duty of candour training. Although there was limited understanding and we did not see evidence where duty of candour had been applied appropriately.

Cleanliness, infection control and hygiene

- Environmental cleaning audits were undertaken monthly at each hospital site in the emergency department (ED) and ambulatory care. Results for September 2015 to August 2016 showed average results of 78% for both areas. Both areas performed consistently below the trust target of 95% for each month of the reporting period.
- We discussed environmental cleaning audits with the nursing staff who told us this had recently been raised with the service leads. There had been a reduction in cleaning hours due to unavailability of cleaning staff. As a result, the department had recently undergone a deep clean. Deep cleaning is a more concentrated programme, complementing on-going cleaning.
- Most areas throughout the ED appeared visibly clean and we observed cleaning staff working during our inspection. However, we saw an examination chair in the plaster room with a torn seat cover and the flooring in the paediatric waiting area was damaged in a number of places. This meant effective cleaning of these areas could not be assured, therefore increasing the risk of cross contamination and spread of infection.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO)

'5 Moments for Hand Hygiene'. These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Results for the reporting period January 2016 to June 2016 showed an average compliance rate of 98% in urgent and emergency services. However, data provided was across three sites and the ED at this hospital did not submit data for three of the six months.

- Processes to address non submission of hand hygiene data included; heads of nursing receiving an email from the quality governance facilitator each month reporting areas that had failed to submit audit data for that month. Heads of nursing would cascade this information to their respective matrons, who were then required to follow up with ward leaders. Matrons were required to report hand hygiene audit data at the monthly infection, prevention and control site meetings. Within that forum they would report their actions to support areas that had not submitted data.
- Throughout the ED the majority of staff were compliant with best practice regarding hand hygiene and staff were noted to be bare below the elbow. There was access to hand washing facilities and a supply of PPE, which included gloves and aprons.
- There had been no cases of clostridium difficile (C. difficile) infections between January 2016 and June 2016. C. difficile is an infective bacterium that causes diarrhoea, and can make patients very ill.
- Meticillin Resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between January 2016 and June 2016 there were no cases of MRSA reported in urgent and emergency services at this hospital.
- There were three designated cubicles in the major's area that could be used to isolate patients who were at risk of spreading infection to others.
- The Care Quality Commission (CQC) uses national surveys to find out about the experiences of people who use NHS services. As part of the CQC Accident and Emergency (A&E) Survey (2014), a questionnaire was sent to 850 people who had attended an NHS A&E department during January, February or March 2014. Responses were received from 294 patients at this trust. The trust scored 'about the same' as other trusts for describing the A&E department as clean.

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Environment and equipment

- Systems, processes and practices essential to keep patients with a mental health condition safe had not been identified. In January 2015, the Department of Health issued an alert to NHS trusts requiring action to reduce the risk of strangulation in children and vulnerable adults from loop cords and chains on window blinds. Whilst we did not see the use of loop cords and chains within the emergency department (ED) we did see a number of ligature points. For example in one of the patient toilets a large hook was attached to the wall. The CQC defines a ligature point as anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. We raised this with the matron for ED and the hook was immediately removed.
- We spoke with the matron and a number of nursing staff about potential ligature points within the ED. Staff showed a limited knowledge of what formed a ligature risk, had no knowledge of what ligature cutters were (ligature cutters are specially designed to offer an effective and safe method of cutting a ligature attached to a person) and had not risk assessed the environment in ED to identify ligature points and minimise risks to patients.
- Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response could be provided by the trust detailing how they were going to address our concerns to minimise risk to patients. In response the trust provided a detailed plan outlining actions they intended to take. We saw actions were specific, measurable, achievable, realistic and timely (SMART). During our unannounced inspection we saw ligature cutters and a risk assessment were available in the department. There was a visible, easily accessible dedicated place for staff to access these. A signature sheet had been started for staff to sign to say they knew where to access them in an emergency and we saw evidence these had been discussed with staff.
- A designated children's waiting area was situated close to the main adult waiting area in the minor's area of the ED. The children's waiting area did not meet Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings (2012). There was no audio-visual separation from the adult's waiting area or access to quieter waiting and treatment areas, and age-appropriate games, music or films for young people. During our inspection an elderly person was sat in this area; we noted there was no sign displayed to indicate this was a children's waiting area. However, there was a sign displayed indicating young children must be supervised at all times.
- In the ED there was a dedicated paediatric cubicle within major's, and one dedicated paediatric resuscitation bed. In the minor's area of the department, cubicles were in close proximity of each other. Whilst, on the day of our inspection, there was not a child in one of the cubicles, we could clearly hear the conversation between the doctor and an adult patient. We spoke with two children who had recently attended the ED. Both described poor experiences of the ED. One child described their experience as, "scary" and "manic".
- Resuscitation and emergency equipment for adults and children was available in all areas in the ED and on the assessment and ambulatory care unit (AAC) and staff were aware of its location in the event of an emergency. However, there was not a robust system in place for checking this equipment. For example, the paediatric resuscitation trolley, stored in the resuscitation area of ED, should be checked weekly in line with trust policy. The checklist for the resuscitation trolley had not been signed for four out of five occasions in June 2016, three out of four occasions in July 2016, two out of five occasions in August 2016 and one out of four occasions in September 2016. In the same area emergency equipment that included oxygen, suction and the defibrillator was to be checked daily however, the checklist for this equipment had not been signed for seven out of 10 days in October 2016. The adult resuscitation trolley, stored in the major's area of ED, should be checked daily in line with trust policy. The checklist indicated this equipment had been checked 28 out of 31 times in August 2016, 28 out of 30 times in September 2016 and 10 out of 10 times in October 2016. The resuscitation trolley in AAC had been checked in line with trust guidelines.
- We could not be assured resuscitation and emergency equipment was safe and ready for use in an emergency. Several single-use items were out of date and on both the adult and paediatric resuscitation trolley, we found an out of date piece of airway equipment. We informed the nurse in charge of this and saw they were replaced immediately.
- An anaesthetic machine was available in the resuscitation room. The anaesthetic machine should be

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checked daily in line with trust policy however, during our unannounced inspection we saw the logbook had not been completed for 19 out of 31 days in August, 14 out of 30 days in September and 16 out of 27 days in October. We raised this immediately with the nurse in charge who told us checks on this equipment were completed by an operating department practitioner (ODP) from theatres. We were not assured the anaesthetic machine would be safe and ready for use in an emergency.

- A difficult airway trolley containing emergency intubation equipment was available in the resuscitation room. Intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway. The 'Plan D' drawer on this trolley contained essential equipment required when a tracheostomy is needed to be formed. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe. We saw where all essential equipment was available in this drawer however, the drawer was over stocked and contained items that would not be required. Difficult Airway Society (DAS) guidance suggests, "Reducing clutter in the trolley drawers means that it is much easier to see and get what you do need in a hurry". However, during our unannounced inspection we saw the difficult airway trolley had been checked weekly in line with trust policy.
- We looked at 11 items of patient-care equipment and three items of equipment to be used in the event of a major incident. All patient-care equipment had been routinely checked for safety with visible safety tested stickers demonstrating when the equipment was next due for service. In relation to the three items of equipment to be used in the event of a major incident, two radiation monitors had no visible service date or evidence of calibration and a portable transformer showed a service date of August 2009. However, information received following our inspection stated the portable transformer should have been disposed of, as it was for use with a decontamination tent that had been replaced. A radiation monitor measures the level of exposure to radiation or radioactive substances.
- Most staff raised concerns with us regarding the size of the department. They felt it was not big enough given the number of patients accessing the department. Between February 2011 and August 2015 the ED at this hospital had seen a 13.2% increase in attendances.

During our focussed and unannounced inspections, at times, the department felt overcrowded with little space available to accommodate additional patients when seating areas and cubicles were full. This meant there was a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell.

- Arrangements for managing waste and clinical specimens mostly kept patients safe and we saw where clinical waste was stored and disposed of appropriately. However we were concerned about the arrangements for the disposal and storage of used sharps. The temporary closure mechanism should be in use on a sharps bin to prevent the accidental spillage of used sharps. During our inspection we observed the incorrect closing of sharps bins throughout the department this meant there was a risk of harm to staff, patients or members of the public. Sharps are needles, blades (such as scalpels) and other medical instruments that are necessary for carrying out healthcare work and could cause an injury by cutting or pricking the skin.
- The location of the ED was within a suitable distance of necessary supporting services for example, theatres, computed tomography (CT), magnetic resonance imaging (MRI) and the helipad were all within close proximity of the department. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

Medicines

- Arrangements for the storage and security of medicines did not always keep patients safe. In the major's area of the emergency department (ED) we saw an unlocked trolley that contained topical disinfectant, local anaesthetics and antibiotic eardrops. Near cubicles nine and 10, also in major's, we saw a skin refrigerant stored on an open trolley. Skin refrigerants are used to control pain associated with pre-injection anaesthesia and minor surgical procedures. In the eye room we saw unlocked drawers where medicines for example, eye drops and topical creams were stored, the door to the eye room was unlocked. We immediately informed the nurse in charge, who arranged for these to be locked away. When we returned to the department some time later the medicines had been removed or stored securely. During our unannounced inspection of the ED we saw all medicines were stored securely.

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- All other medicines throughout the department, including intravenous fluids were stored securely and we saw controlled drugs were stored and managed appropriately. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs.
- Between August and October 2016 the ED took part in the trust safe and secure handling of medicines audit. The audit was based on guidance from NHS Protect who, as part of their remit to provide a safe and secure environment for the delivery of NHS care, provide policy and operational guidance to providers of healthcare on the security of all medicines, including controlled drugs and prescription forms which provide access to medicines. Results for the department were 95% and better than the overall trust compliance of 87%.
- Medicines requiring refrigerated storage were stored at the correct temperatures to ensure they would be fit for use.
- We looked at medicine administration records for 10 patients. We saw appropriate arrangements were in place for recording the administration of medicines. The hospital used a paper-based prescribing and medication administration record system for patients. Records were clear and fully completed. The records showed patients were getting their medicines when they needed them. Allergies to any medicines were recorded on all 10 medicine administration records.
- An antimicrobial prescribing policy was available in the ED and provided a framework for staff to ensure the safe and appropriate prescribing of antibiotics.
- There was an antimicrobial stewardship strategy group (ASSG) which had responsibility and ownership trust wide for promoting the appropriate use of antibiotics as part of effective infection prevention and control. Membership included antimicrobial pharmacists, consultant microbiologists, senior members of the infection prevention and control team and consultant representatives from other specialities.
- We looked at medicine administration records for 10 patients. Medicine administration records showed antibiotics were prescribed in line with local microbiology protocols and National Institute for Health and Care Excellence (NICE) guidance. For example, stop/start and review date prompts were included on all records.
- Registered nurses working in the ED were working under patient group direction (PGD) for the prescription of simple pain relief, oxygen and glyceryl trinitrate (GTN). GTN is used for the treatment of chest pain. Patient group directions provide a legal framework allow some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.
- Medicine prescription pads were stored in the controlled drugs cupboard that was only accessible by clinical staff. This met NHS guidance (2013) which suggests prescription forms should be kept in a locked cabinet within a lockable room or area. The use of prescription pads were monitored through the recording of the individual serial numbers for each sheet.
- The consultant nurse and advanced care practitioners (ACPs), working in the ED, were non-medical prescribers. Non-medical prescribing is the prescribing of medicines and dressings by health professionals who are not doctors. This meant patients were seen and treated quicker as they did not have to wait to see a doctor. A consultant nurse is an advanced practitioner who provides expert clinical advice to patients, carers and other health care professionals within a defined speciality. ACPs are specialist nursing staff that perform effectively in an equivalent role to a junior doctor.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for having the purpose of new medications explained before they left A&E and for being told about possible side effects of medication, for those prescribed new medication while in A&E.

Records

- During our inspection we reviewed 21 adult and 13 paediatric patient records. We saw individual care records were written and managed in a way that kept patients safe. Records were accurate, complete, legible and stored securely.
- Nursing staff confirmed, when required, patient records would include risk assessments, such as for falls, pressure care and nutrition and they would be reviewed and updated on a regular basis. However, risk assessments were not always appropriately completed. For example, we reviewed the record of one patient who had been in the emergency department (ED) for more

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than six hours and saw that staff had not completed a pressure ulcer risk assessment, in line with best practice and in five records, where required, we could not see evidence that a venous thromboembolism (VTE) assessment had been carried out.

- Patient records in the ED and assessment and ambulatory care unit (AAC) were paper-based and held at the nurse's station in each area of the departments. We observed notes could be seen at all times by a member of trust staff. This meant that there was minimal risk of access to a patient's medical notes by an unauthorised person.
- Paediatric records were easily identifiable through the use of a coloured label. Blue labels were used to identify children from nought to 10 years and a navy label for children from 10 to 16 years. We observed 13 sets of paediatric records and saw where the appropriate coloured label had been placed on the record.

Safeguarding

- The executive lead for safeguarding was the director of nursing who was supported by the deputy chief nurse. There was a named professional for safeguarding adults who was supported by a safeguarding practitioner. There was a named nurse for safeguarding children and young people also supported by a safeguarding practitioner.
- An adult safeguarding practitioner delivered a 20 minute safeguarding session to staff in the emergency department (ED) twice a week. During our inspection we observed a session on domestic abuse. Sessions included support on how/who to refer to relevant agencies.
- Staff in the ED at Lincoln County Hospital received safeguarding of vulnerable adults training (level one, two and three) as part of their mandatory training. Information received before our inspection showed completion rates for levels one and two were below the trust target of 95%. As of 31 August 2016, 89% of medical staff and 87% of nursing staff had completed level one safeguarding adults training. For the same reporting period 77% of staff (medical and nursing combined) had completed level two safeguarding adults training. Information received following our inspection showed to date 93% of nursing staff had completed safeguarding of vulnerable adults training at level three.
- Staff received safeguarding children and young people training (levels one, two and 3a) as part of their mandatory training. Information received before our inspection showed completion rates for levels one; two and 3a were below the trust target of 95%. As of 31 August 2016, 89% of medical staff and 90% of nursing staff had completed level one safeguarding children and young people training. For the same reporting period 79% of staff (medical and nursing combined) had completed safeguarding children and young people training at level two and 67% at level 3a.
- Nursing and medical staff used a 'SAFER' communication tool, based on Department of Health guidelines, for all paediatric patients admitted to the emergency department and for the identification and management of children at risk of abuse. SAFER communication guidelines are guidelines for communications between staff in the department, health visitors, school nurses and local authority children's social care teams and are used when a child may be suffering or is likely to suffer significant harm. The use of SAFER ensured a uniform approach to communicating the level of risk to a child. We saw the appropriate use of the SAFER communication tool in all 13 paediatric patient records we reviewed.
- The ED was not part of the 'Child Protection - Information Sharing' (CP-IS) project. CP-IS is a nationwide system that enables child protection information to be shared securely between local authorities and NHS trusts across England. Nursing and medical staff were alerted if a child they were treating was subject to a child protection order or local authority care through the trust electronic clinical information system.
- There were processes in place for the identification and management of people at risk of abuse (including domestic violence). Staff followed a robust risk assessment process in order to refer patients, where appropriate to a Multi-Agency Risk Assessment Conference (MARAC). A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.
- Arrangements were in place to safeguard patients or children with, or at risk of, female genital mutilation (FGM). Female genital mutilation/cutting is defined as the partial or total removal of the female external

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genitalia for non-medical reasons. Nursing and medical staff received FGM training as part of their training for level three safeguarding adults. Nursing staff told us they would consider a referral to MARAC form if they felt it appropriate.

Mandatory training

- The trust target for mandatory training was 95%. Information received before our inspection showed completion rates for staff in the emergency department (ED) at Lincoln County Hospital were below the trust target across all subject areas. As of 31 August 2016, completion rates for medical staff were; fire safety 67%, infection control 44%, equality, diversity and human rights 78%, information governance 89%, health and safety 78%, slips, trips and falls 78%, moving and handling 78%, risk awareness 78%, fraud awareness 56% and basic life support 0%. For the same reporting period completion rates for nursing staff were; fire safety 63%, infection control 49%, equality, diversity and human rights 94%, information governance 66%, health and safety 88%, slips, trips and falls 86%, moving and handling 86%, risk awareness 69%, fraud awareness 64% and basic life support 50%.
- A trust wide policy for sepsis management was available to staff and could be accessed through the trust intranet. The policy provided guidance to staff on identifying appropriate physiological observations, recognising the deteriorating and/or patient with sepsis and identifying the immediate actions health care professionals should take having recognised a deteriorating patient and/or patient with sepsis.
- Between 12 August and 4 October 2016, a total of 23 staff in the department had received training on sepsis through an online e-learning module. Of these, 13 were nurses. The total number of nurses in the ED was 73 staff. One nurse had received training on the assessment and ambulatory care unit (AAC).
- The ED was a receiving centre for major trauma patients. At the time of our inspection 15 staff had completed the advanced trauma nursing course (ATNC) with an additional four staff booked to attend training.
- Mandatory training was accessed either through an electronic learning tool or, for some subjects, face to face. Nursing staff told us face to face training was sometimes difficult to attend because it was held on

different days and would often only be for a few hours, this meant they would often have to leave the department to attend. If the ED was busy they would not be able to attend.

Assessing and responding to patient risk

- The Department of Health target states handovers between ambulance and emergency departments must take place within 15 minutes with no patients waiting more than 30 minutes. The trust was not meeting this target. For the period August 2015 to July 2016, there were 3,071 black breaches at this trust. Black breaches are those cases where it has taken over one hour from the time the ambulance arrives at a hospital, until the clinical and patient handovers have taken place.
- For the period September 2015 to August 2016, compliance figures for ambulance handover times showed 27.3% of handovers took greater than 30 minutes. Of these 4.9% took between one and two hours and 0.7% took greater than two hours. However, figures provided were taken from a report produced by the local NHS ambulance trust and included all ambulances presenting to this hospital, not just those that arrived at the emergency department (ED). The trust was unable to separate out those relevant to the ED.
- For August 2016, data provided by the trust showed 69% of ambulance handovers took greater than 15 minutes, 20% over 30 minutes and 10% of ambulance handovers took greater than 60 minutes to complete. Only 1% of ambulance handovers took place within 15 minutes.
- During our inspection we observed nine patients arrive by ambulance, only one ambulance handover took place within 15 minutes, ambulance handover times for the remaining eight patients varied between 19 and 45 minutes.
- Not all patients who self-presented to the department received an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival. Following our inspection the trust provided us with data on triage times for patients self-presenting to the department. Data provided for September 2015 to August 2016 showed an average of 65% of patients did not receive an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival.
- During our inspection we reviewed 13 paediatric patient care records and saw where eight patients had received

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an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival, four were between 15 and 30 minutes and two were greater than 30 minutes.

- Nursing staff used a national early warning scoring system (NEWS) and paediatric early warning scoring system (PEWS) to record routine physiological observations such as for example, blood pressure, temperature, and heart rate in adults, children and young people. Early warning scores facilitate early detection of deterioration by categorising a patient's severity of illness and prompting nursing staff to request a medical review at specific trigger points.
- Compliance with NEWS/PEWS scoring and escalation of patients who triggered or were deteriorating was monitored monthly. We reviewed the data for urgent and emergency services (trust wide). Data for 10 months (data for March and April 2016 was not included) between July 2015 and June 2016 showed an overall average compliance score of 72% for correct patient details, 90% for patient observations on time and complete, 93% for PEWS/NEWS score added correctly and 63% for evidence of escalation for NEWS if required. The trust target for all four elements was 90%.
- Our review of 16 observation charts showed nursing staff did not always adhere to trust guidelines for the completion and escalation of NEWS; one chart had no frequency of observations recorded, one chart had not had the NEWS calculated, on one chart the NEWS was incorrectly calculated, one chart had not had observations repeated after two hours as requested by the doctor and four out of 16 charts did not include a sepsis screen despite a NEWS of five or more.
- We did not see a system for displaying early warning scores for all patients in the department, so staff could see where closer observation was required. We discussed this with the nurse in charge who told us the electronic board used to display patient activity in the department had been due to be updated to include NEWS, however this had been delayed to the week after our inspection. We saw on the assessment and ambulatory care unit (AAC) NEWS was displayed. During an evening visit to the ED we observed a staff nurse verbally updating the nurse in charge about a patient's NEWS score.
- Patients with a suspected infection or a NEWS of five or more were to be screened for sepsis, a severe infection which spreads in the bloodstream, using a 'Sepsis Identification Checklist and Care Bundle'.
- Patients being treated for sepsis were to be treated in line with the 'Sepsis Six Care Bundle'. The 'Sepsis Six' is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis if given within an appropriate period. There is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour.
- Data provided by the trust for October 2015 to September 2016 showed that on average 50% of patients diagnosed with sepsis were receiving antibiotics within one hour, however compliance varied month to month with the lowest compliance at 15.7% (October 2015) and highest 75% (December 2015).
- During our inspection, we met with the quality and safety manager and associate medical director who were the overall leads for sepsis management throughout the trust to discuss their plans to improve performance on the management of sepsis. There were plans in place to improve performance across wards and admission areas including ED. This included sepsis boxes in all areas, the introduction of a patient group direction (PGD) for intravenous meropenem (a broad-spectrum injectable antibiotic used to treat a wide variety of infections), recruitment of two full-time sepsis nurses, working in partnership with a local NHS ambulance provider and the roll-out of an electronic learning package. The quality and safety manager and associate medical director told us they were confident there would be an improvement in sepsis management and treatment within six months of our inspection.
- During our inspection we reviewed 15 adult and one paediatric patient observation charts in the ED. We found there was not always an effective system in place to deliver sepsis management in line with relevant national clinical guidelines. So as to identify patients with sepsis, determine appropriate levels of care and treatment and continue to provide appropriate care and treatment for patients with sepsis.
- Four out of 16 patients had not been screened for sepsis despite a NEWS of five or more. Where antibiotics were indicated as part of the sepsis six care bundle, eight out

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of 11 patients did not receive antibiotics within one hour. Delays varied from four minutes to 169 minutes. On one occasion a member of our inspection team had to prompt the medical staff to consider a sepsis screen and implement the sepsis six care bundle. This patient triggered the sepsis pathway at 11.21am with a NEWS of six. The patient was screened at 1.05pm when prompted by a member of our inspection team. Antibiotics were prescribed at 2.44pm and administered at 3.10pm; three hours and 49 minutes after the initial trigger.

- On another occasion a patient was admitted to the ED with neutropenic sepsis. Neutropenia is a low level of neutrophils, a type of white blood cell that helps the body fight infection. Neutropenic sepsis is a serious condition, which can be life-threatening so it must be treated urgently. This patient triggered the sepsis pathway at 6.50pm with a NEWS of five. The patient was screened for sepsis at 7.30pm. Antibiotics were administered at 9.10pm; two hours and 20 minutes after the initial trigger.
- Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response could be provided by the trust detailing how they were going to address our concerns to minimise risk to patients. In response the trust provided a detailed plan outlining actions they planned to take. We saw actions were specific, measurable, achievable, realistic and timely (SMART). During our unannounced inspection we saw where the ED sister had discussed the concerns raised with staff in the department. We were shown where a new process had been implemented to appropriately identify patients who may require screening for sepsis whereby any patient with a raised NEWS had the sepsis screening tool place in their records ready for their first clinical assessment. All staff were now expected to raise a patient safety incident where sepsis had not been applied appropriately. We saw where three sepsis-related incidents had been raised appropriately.
- Staff in the ED referred to a trust wide patient transfer policy to ensure the safe and timely transfer of patients; however, this policy had been due for review in January 2013. Three members of staff were not aware of this policy. This could mean a risk to a patient's safety which may adversely influence their morbidity and mortality.

Two members of staff told us there was not always staff available to escort patients. In these instances the site duty manager would go down to the ED to assist or the porter would transfer the patient without an escort.

- Patients attending the minor's area of the department were first seen by the receptionist who took details and then placed their record in the triage box. Patients were then seen in arrival order unless the receptionist identified their condition required immediate review. Reception staff told us they had no specific medical training. They told us if a patient was bleeding heavily or if they had chest pain they would escalate this to the triage nurse for an immediate review. We were told by junior and senior reception staff and the nurse lead that there was no standard operating procedure of how or when the receptionists should escalate any concerns.
- A qualified nurse triaged patients using a process based on the Manchester triage system. The Manchester triage system is a clinical risk management tool used to determine how quickly a patient needs to receive medical treatment. Depending on the severity of their ailment, the nurse streamed patients to the appropriate route such as the minor or major area of the department.
- The department had recently introduced a rapid assessment and treat (RAT) process, this assisted in reducing delays to treatment at times when the department was busy and ambulance patients were awaiting a bed. RAT involves the early assessment of major's patients in emergency departments, by a team led by a senior doctor and advanced care practitioner (ACP), with the initiation of investigations and/or treatment. Evidence has shown outcomes and the patient experiences are greatly improved when a RAT process is used. However, senior leaders told us the RAT process was not consistently in use due to shortfalls in staffing. Currently the process was used Monday to Friday from 10am to 6pm. Future plans included increasing this service to 10pm and the department had recently recruited an additional five advanced care practitioners (ACPs) to support this process.
- Paediatric patients admitted to the ED were assessed and cared for largely by adult registered nurses. During our inspection we observed on two occasions where a paediatric patient was being cared for by registered nurses who were not trained to care for children. Of the two nurses only one had received paediatric life support training.

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- Where a paediatric patient was admitted and was acutely unwell and/or their condition was deteriorating, staff in the ED had immediate access to a paediatric emergency response team (PERT) contactable through a bleep system. There were no patients, during our focussed or unannounced inspection that required the assistance of the PERT. During our inspection we saw guidelines displayed in the resuscitation area advising staff how/when to access the PERT.
- During our focussed and unannounced inspection there was a member of the medical staff on duty who had been trained in European paediatric advanced life support (EPALS).
- The department inputted hourly data into an ED specific risk tool which had been created to give an internal escalation level within ED separate to the site operational escalation level. This tool gave an 'at a glance' look at the number of patients in ED, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building and there were local actions for easing pressure. Senior leaders used this to monitor the status of the department. This meant additional resources could be put into the department when required. During our unannounced inspection the risk score in the ED had been identified as a 'black risk' (extreme risk) and we saw where appropriate actions were being taken by the hospital duty manager. These included, discussions with the nurse in charge and additional staff being directed to the department.
- A pre-alert phone was available in the department to enable ambulance crews to alert the department to the imminent arrival of an acutely unwell patient. We observed staff responding quickly to a pre-alert and saw where they recorded information on a standardised form that ensured all key information was noted.
- Patients were appropriately referred to the assessment and ambulatory care unit (AAC). A patient escalation policy was in place which included the admission criteria for the unit and staff were aware of when they would need to use this.

Nursing staffing

- Urgent and emergency services used the 'Baseline Emergency Staffing Tool' (BEST) to plan nursing staffing requirements to ensure there was adequate cover of all areas including triage, minors and majors and resus

across the full 24 hour period. The BEST has been designed to estimate emergency department (ED) nursing staffing requirements based on a combination of the number of patients attending the department, and a measure of the patients' nursing dependency. Nursing staff told us the last BEST review had been completed at the end of 2016. Not all staff were aware of the outcome but a senior nurse told us the review indicated a total of 15 nurses (a combination of registered and unregistered) were needed to safely staff the department. The BEST tool indicated the department should have 15 nurses per shift. The current level of staffing in the ED met or exceeded National Institute for Health and Care Excellence (NICE) recommended levels (2015).

- Information received before our inspection showed the vacancy rate in the ED to be 3.3 whole time equivalent vacancies (6.8% of the total nursing establishment). At the time of our inspection the nursing sister for the department told us the department was soon to be fully established once recruitment checks had been completed. However, despite a full establishment of nursing staff the department currently had nine whole time equivalent staff who were not available to work due to long term sickness and maternity leave.
- Bank and agency nurses were used to maintain staffing levels in the ED. Information received before our inspection for the reporting period April 2015 to March 2016 showed an average bank / agency use of 12.8%. Bank/agency had only been used for two out of the 12 months, in the assessment and ambulatory care unit (AAC), for the same reporting period with usage reported to be 1.2% in May 2016 and 12.4% in June 2016.
- There were arrangements in place for the induction of bank and agency staff who had not previously worked in the ED, which included a checklist to be completed once an induction had taken place. We observed this during our inspection.
- From March to June 2016, the average fill rate for registered nurses in the ED was 88% during the day and 98% at night. The average fill rate for un-registered nurses was 94% during the day and 98% at night. The fill rate refers to the number of hours planned for the department to care for patients compared to the actual hours that were filled. This had improved from previous

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months where for example, between December 2015 and March 2016, the average fill rate for registered nurses in the ED had been 60% during the day and 78% at night.

- During an evening visit to the ED we saw the use of four bank staff, out of a planned establishment of seven staff, to cover a shortfall in the staffing rota due to sickness at short notice. We discussed this with the sister the following day who told us it was not usual to use this number of bank staff during a shift but that all the bank staff used were known to the department. The sister also told us the establishment for seven staff at night was under review with plans to increase the rota with an additional registered nurse. Staff could not tell us when this would happen.
- At the time of our inspection the ED was in the process of recruiting three senior registered nurses to undertake a flow-coordinator role within the department from 10am to midnight, seven days a week. The purpose of this role was to support the nurse in charge to manage the flow of patients through the department and release the nurse in charge in order to oversee the delivery of clinical care throughout the department.
- A team of three emergency nurse practitioners (ENPs) worked between 10am and 10pm, seven days per week. ENPs worked in the minors area of the ED. Recruitment was underway for a further three ENPs.
- There was a team of nine advanced care practitioners (ACPs) and a consultant nurse employed within the department with an additional five ACPs currently awaiting start dates.
- The Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings 2012 and Royal College of Nursing Standards 2013 state that a minimum of one paediatric trained nurse should work on each shift. There was 1.84 whole time equivalent trained paediatric nurses employed in the ED. This was not sufficient to meet this standard. We discussed this with the matron for the ED who told us in order to meet this standard there would need to be 5.26 whole time equivalent trained paediatric nurses. On the first day of our inspection there was not a paediatric trained nurse in the department however, during an evening visit on the same day the nurse in charge was trained in both adult and paediatric nursing. There were no registered

nurses within the ED with specific paediatric competencies. The 1.84 whole time equivalent trained paediatric nurses were the overall leads for children's care in the department.

- We reviewed the nurse staffing rotas for 30 May 2016 to 4 September 2016 and saw over a period of 98 days there was not a minimum of one registered children's nurse present in 62 out of 98 day shifts and 67 out of 98 night shifts. On six occasions during the same period we saw where two registered children's nurses were on duty on the same shift.
- Nursing staff handovers occurred at each shift change and included discussions about patient needs and any staffing or capacity issues. ED nursing staff were using a handover tool 'STOP' (S-social and care needs, T-treatments, O-observations, P-plan) as an effective and efficient way to communicate important information during handover.

Medical staffing

- The proportion of consultant cover in the emergency department (ED) was lower than the England average. The Royal College of Emergency Medicine guidelines indicate that a 24 hour, seven day a week ED should provide consultant presence in the ED for 16 hours per day with appropriate nursing and middle grade doctor support. As of October 2016, weekday consultant, on site, presence for the ED was 14 hours. At weekends there was a reduced consultant on site presence of 12 hours. At all other times consultant presence was through on-call arrangements.
- Middle grade doctors covered the 24-hour period, seven days a week. A middle grade doctor is a junior doctor who has more experience than a senior house officer (SHO, now FY2), but less than a consultant. Middle grade doctors included staff grade, clinical fellows and specialist registrars (ST1, ST2, ST3). There was a minimum of an ST4 or equivalent in the department 24 hours a day, seven days a week.
- The proportion of junior doctors reported to be working in the ED was higher the England average. A junior doctor rota provided 24-hour cover, seven days a week with additional junior doctors on duty during periods of high demand.
- As of August 2016 there were three whole time equivalent consultant posts filled out of a funded establishment of seven and 2.6 whole time equivalent middle grade posts filled out of a funded establishment

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of 11. Locum consultants and middle grade doctors were used to fill vacant posts with locum staff employed through a 'block booking'. This meant there was continuity of care within the department and ensured locums were familiar with the area.

- As of 30 June 2016, Lincoln County Hospital reported a vacancy rate of 32.1% in Urgent and Emergency Care; this was based on 9.4 whole time equivalent vacancies.
- Between April 2015 and March 2016 the average turnover rate was 52.4% in the ED, this was based on 11 whole time equivalents. Turnover rate is the percentage of employees in a workforce that leave during a certain period of time.
- Between April 2015 and March 2016, Lincoln County Hospital reported a bank and locum usage rate of 55% in the ED.
- During our inspection twelve members of staff raised concerns about medical staffing in the department including the use of locum doctors. Concerns raised included for example, seniors were not always available to discuss patients with, locum doctors being unfamiliar with systems and processes within the department, poor medical leadership, lack of clarity around who was the 'consultant of the day' and insufficient numbers of middle grade doctors at night. However, most staff told us senior doctors were supportive and approachable.
- The department had recently introduced, as a trial, an additional middle grade doctor at night therefore increasing the number to three to help address the increasing number of patient attendances. This had only been running for four weeks and when an additional doctor was available medical staff felt it helped. However, an additional middle grade was not always available leaving the department with gaps of one or two middle grade doctors.
- Information due to be submitted to the trust board in November 2016 showed significant recruitment activity had been underway, since August 2016, to increase the number of middle grade staff at this hospital. Eight applications had been received for middle grade posts in the ED. To date three had been interviewed, one was still to be interviewed, one failed to attend their interview, one declined to be interviewed and for two the trust was trying to contact to arrange interviews. Offers of employment had been made to three with one accepting an offer of employment at this hospital with a likely start date of January/February 2017. In addition to this one general practitioner (GP) had expressed an

interest to work in the ED short term and was due to start soon. Royal College of Physicians approval had been obtained for the remaining vacant consultant posts and adverts were due to be placed soon.

- Medical handover took place every morning, seven days a week between the oncoming and outgoing staff. During handover medical staff discussed all patients within the department in addition to any incidents, staffing issues, complaints or concerns that may have arisen in the previous 24 hours. A further two handovers took place at 1pm and 6pm between the responsible consultants for the shift but these did not include the wider medical team.

Major incident awareness and training

- There were not robust arrangements in place to respond to emergencies and major incidents. A major incident plan and action cards were available but were not in date nor were they easily accessible to staff. The purpose of a major incident plan is to provide a framework for the trust to respond in a co-ordinated manner to a major incident or an internal trust declared incident.
- The major incident policy was kept in sister's office and was accessible by a key pad. This meant it was not always easily accessible to all staff. A major incident plan, dated 2016, was provided by the trust before our inspection however, the plan available in the department was out of date.
- A major incident cupboard was available in the department. This contained consumables and equipment that would be required in the event of a major incident. Consumables in the major incident cupboard were out of date with some showing expiry dates as early as 2007. Intravenous fluid (normal saline) had expired in 2014. We saw two radiation monitors with no visible service date or evidence of calibration and a portable transformer showed a service date of August 2009 and was also leaking fluid. The trust told us the portable transformer should have been disposed of, as it was for use with a decontamination tent that had been replaced. Action cards were available but duplicated and stored in different areas. These were not up to date for example, using the bleep number provided on action card two we bleeped the emergency care matron; the matron for medicine answered the bleep. During our review of this cupboard we asked department staff to contact the trust emergency

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planning officer and silver command; neither individual answered their bleeps. A gold–silver–bronze command structure is used by emergency services of the United Kingdom to establish a hierarchical framework for the command and control of major incidents and disasters.

- Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response could be provided by the trust detailing how they were going to address our concerns to minimise risk to patients. In response the trust provided a detailed plan outlining actions that were to be taken to address our concerns. We saw actions were specific, measurable, achievable, realistic and timely (SMART). During our unannounced inspection we saw staff in the department had addressed all our concerns; there were two trolleys and a major incident cupboard available to store all required consumables and equipment necessary for responding to an emergencies and/or major incident, consumables were within their expiry date, radiation monitors were due to be sent to clinical engineering for calibration within a week and an up-to-date major incident policy, escalation policy and action cards were accessible to staff and we saw evidence these had been discussed with staff. We were therefore subsequently assured there were robust arrangements in place to respond to emergencies and major incidents.
- The Emergo programme forms part of the Public Health England (PHE) funded programme directed by the emergency preparedness, resilience and response (EPRR) partnership board chaired by the Department of Health. PHE works with national and local government, industry and the NHS to protect and improve the nation's health and support healthier choices. The Emergo Train System (ETS) is a mass casualty simulated system for teaching, demonstrating and testing a whole system medical response to major incidents. It can be used by hospitals as a cost effective way to exercise, test and evaluate the medical response to a large scale incident, provided that a clear aim, objectives and measurable performance indicators are agreed in advance of the exercise.
- The United Lincolnshire Hospital Trust (ULHT) emergo exercise took place on 17 June 2015 at the same time across all three Trust sites, Lincoln, Boston and Grantham. Results of this exercise were largely positive and showed overall the trust managed the response to the incident well with very few patients being put at risk

of a preventable death or preventable complication. Hospital sites were noted to have communicated and worked well together, good leadership was shown in all departments and the trust achieved all of the objectives set for the exercise.

- There was 24 hour seven days per week security cover available at Lincoln County hospital. However, staff told us only one member of security staff would be available overnight. Where further security assistance was required staff told us they would contact the police through a 999 call.
- As of October 2016 the percentage of staff in the ED that had received training in conflict resolution was 77%. Conflict resolution is a way for two or more parties to find a peaceful solution to a disagreement among them.
- Closed-circuit television (CCTV) was in place in the department with a central screen located in the main security office. Panic buttons, for summoning help in an emergency, were in place in all patient cubicles and the triage and quiet rooms.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



We rated the effectiveness of urgent and emergency services as requires improvement because patients were at risk of not always receiving effective care and treatment.

We found:

- Systems and processes were not established and operating effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients with a mental health condition or those experiencing mental distress. The trust did not have a policy for the assessment, management and care of adult patients who attended the emergency department (ED) due to self-harming behaviours or suicidal intent, nor had staff received training regarding their responsibilities in line with legislation and guidance, including The Mental Health Act (1983).

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- Staff did not consistently adhere to local guidelines for sepsis screening and the trust had a higher than expected hospital standardised mortality ratio (HSMR) in the area of sepsis.
- Royal College of Emergency Medicine (RCEM) audit results showed outcomes for patients were sometimes below expectations when compared with similar services.
- The rate of unplanned re-attendance to the emergency department within seven days was worse than the 5% national standard set by the Department of Health.
- Nursing staff were not always managed or developed effectively. Not all nursing staff had received an annual appraisal and appraisal completion rates had significantly declined since the previous year.

However, we also found:

- Patient's care and treatment was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to the National Institute for Health and Care Excellence (NICE) quality standards.
- The department was managed efficiently by the nurse in charge. The department appeared calm and risks to patients were minimal including during those times where it had been identified the department was under extreme pressure.
- Patient's symptoms of pain were suitably assessed and managed appropriately and in line with the Faculty of Pain Medicine's Core Standards for Pain Management (2015)
- There was effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff were qualified and had the skills they needed to carry out their roles effectively.
- Staff had a good understanding of the relevant consent and decision making requirements of legislation and guidance and consent to care and treatment was appropriately obtained.

Evidence-based care and treatment

- In January 2016 the Royal College of Emergency Medicine (RCEM) launched the CLEAR Campaign. CLEAR is a five point plan to improve emergency mental health care. As part of this plan RCEM recommends a patient who is experiencing mental distress should be seen within one hour of referral to mental health services. A mental health liaison team (MHLT), provided by a

neighbouring NHS mental health trust was accessible to the ED 24 hours a day, seven days a week. Four out of seven adults presenting to the department during our inspection did not have a review by the MHLT within one hour of arrival, one did not have a review time recorded and one patient self-discharged before being reviewed. Whilst awaiting a review by the MHLT there were no further resources to support healthcare professionals in caring for this group of patients. For example, the trust did not have a policy for the assessment, management and care of adult patients who attended the ED due to self-harming behaviours or suicidal intent, nor had staff received training regarding their responsibilities in line with legislation and guidance, including The Mental Health Act (1983). The Mental Health Act governs the involuntary admission and treatment of persons with mental disorders. It provides criteria for their rights notification, second medical opinions, renewal certificates, review panels, and other related issues.

- Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response could be provided by the trust detailing how they were going to address our concerns to minimise risk to patients. In response the trust provided a detailed plan outlining actions that were to be taken to address our concerns. We saw actions were specific, measurable, achievable, realistic and timely (SMART). Actions included developing a clinical guideline regarding the care and treatment of patients with mental health conditions and contacting a local NHS provider of mental health services to request assistance in developing a training package for the ED staff regarding the care of the mental health patient.
- There were no protocols in place for the management and manipulation of fractures or fractured neck of femur (a crack or break in the top of the thigh bone). This did not meet national guidance and meant there was a risk that patients requiring manipulation of fractures or who had experienced a fractured neck of femur may be mismanaged.
- Procedures, policies and clinical guidelines were easily accessible through the trust's intranet. We looked at five policies and procedures and eight clinical guidelines on the trust's intranet and saw these were up to date and reflected national guidance including the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM).

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- Care pathways; multidisciplinary plans of anticipated care and timeframes were in place for specific conditions or sets of symptoms. Pathways were in line with national guidance and included for example, pathways for sepsis, stroke, acute kidney injury, venous thromboembolism (the formation of blood clots in the vein), asthma, urinary catheter care (urinary catheters are hollow tubes that collect urine from the bladder) and peripheral venous catheters (a small, flexible tube placed into a peripheral vein in order to administer medication or fluids). We reviewed 21 adult patient care records during our inspection and observed the use of care pathways. Where generic pathways were in use we saw these individualised to meet the specific needs of the patient. However, staff did not consistently adhere to local and national guidelines for sepsis screening.
- We saw emergency pathways in place for example a major haemorrhage protocol, traumatic cardiac arrest and a head injury and staff gave us examples of when they may be used.
- The effectiveness of care and treatment was regularly reviewed through local and national audits. Information received before our inspection showed the emergency department (ED) were currently participating in three local audits and a re-audit of compliance against the National Institute for Health and Care Excellence (NICE) clinical guideline (CG124): Hip fracture: management.

Pain relief

- The Faculty of Pain Medicine's Core Standards for Pain Management (2015); Standards 2 and 3 were implemented across the ED. For example, a 'pain aid tool' was available for patients who could not verbalise and/or may have a cognitive disorder and pain was assessed and documented in 32 out of 34 (adult and paediatric) patient records we reviewed.
- The trust did not carry out an annual audit to ensure all children were offered pain relief within 20 minutes of arrival to the emergency department (ED) and those in severe pain were reassessed every hour. This was not in line with the recommendations of The Royal College of Emergency Medicine (RCEM) guidelines; Management of Pain in Children (revised July 2013).
- We reviewed 13 patient records of children and young people and saw nine out of 13 children were offered pain relief within 20 minutes of arrival to the ED. None of

the records we reviewed suggested the child was in severe pain. In the 21 adult patient records we reviewed pain scores were recorded as part of triage and pain relief administered where required in 19 out of 21 cases.

- Patients we spoke with had been asked about their pain and given pain relief where appropriate at regular intervals and we saw, on a number of occasions, where the pain of individual patient's was assessed and managed appropriately.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for not having a long wait to receive pain relief if requested and for feeling that hospital staff did all they could to help control their pain, if they were ever in pain while in A&E.

Nutrition and hydration

- Arrangements were in place to ensure food and drink was available for patients (and accompanying friends and family) who were in the department for any length of time. During our inspection we observed staff providing patients with food and drinks. All the patients we spoke with told us they had been offered food and/or fluids whilst they had been in the department.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for being able to access suitable food and drink while in A&E, if they wanted to.

Patient outcomes

- There was a consultant lead for audit in the emergency department (ED). The department participated in national Royal College of Emergency Medicine (RCEM) audits so they could assess their practice and performance against best practice standards in order to assess their practice and performance against best practice standards. Audits included, for example, the monitoring of vital signs in children and assessing the risk of venous thromboembolism (VTE).
- In the 2014/15 RCEM audit for initial management of the fitting child, the trust performed similar to other trusts for three of the six measures for Lincoln County Hospital. The trust performed worse than other trusts for the fundamental standard of checking and documenting blood glucose for the fitting child at Lincoln County Hospital.
- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, the trust performed similar

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to other trusts for five of the six measures for Lincoln County Hospital. The trust performed worse than other trusts for the fundamental standard of having an Early Warning Score documented at Lincoln County Hospital.

- In the 2014/15 RCEM audit for mental health in the ED, the trust performed worse when compared to other trusts for four of the six measures for Lincoln County Hospital. Of the two fundamental standards included in the audit, the trust performed worse than other trusts for the fundamental standard of having a documented risk assessment taken and having a dedicated assessment room for mental health patients at Lincoln County Hospital.
- In the 2015/16 RCEM audit for procedural sedation in adults the trust performed worse than the England average for all seven standards for Lincoln County Hospital. This included the four fundamental standards; patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities, procedural sedation included the presence of a doctor, a second doctor, an ENP or ANP and a nurse and monitoring during procedural sedation must be documented and include; non-invasive blood pressure, pulse oximetry, capnography and an ECG.
- In the 2015/16 RCEM audit for Vital Signs in Children the trust performed worse than the England average for three of the six measures for Lincoln County Hospital. The trust performed worse than the England average for the fundamental standard of all children attending the ED having a set of vital signs consisting of temperature, respiratory rate, heart rate, oxygen saturation and conscious level score documented within 15 minutes of arrival or triage. The trust performed better than the England average for the fundamental standard of having documented evidence that the abnormal vital signs (if present) were acted upon in all cases.
- In the 2015/16 RCEM audit for VTE Lincoln County Hospital performed the same as the England average for the fundamental standard; if a need for thrombo-prophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment and better than the England average for the standard; evidence that a patient

information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation.

- Departmental audit meetings took place twice yearly. Audits were reviewed and action plans were developed to improve where shortfalls had been identified. For example, the ED had developed and implemented an adult procedural sedation proforma and guidelines, improved documentation of paediatric early warning scores (PEWS) and improved documentation of the risk and preventative treatment of VTE.
- The rate of unplanned re-attendance to the emergency department within seven days was 6.9% between September 2015 and August 2016. This was worse than the 5% national standard set by the Department of Health but consistently better than the England average for all 12 months.
- The trust did not take part in the RCEM 2016 consultant sign-off audit and was not therefore able to provide assurance that a consultant review prior to discharge occurred in the following four high-risk patient groups; atraumatic chest pain in patients aged 30 years and over, fever in children under one year of age, patients making an unscheduled return to the ED with the same condition within 72 hours of discharge and abdominal pain in patients aged 70 years and over.

Competent staff

- The learning needs of staff were identified through their annual appraisal. However, not all staff had received an annual appraisal. For the 12 month period ending July 2016, 39.4% of nursing staff within the emergency department had received an appraisal at Lincoln County Hospital. This was worse than the 12 month period ending July 2015, where 76.1% of staff had received an appraisal.
- For the 12 month period ending July 2016, 89% of medical staff within the emergency department had received an appraisal at Lincoln County Hospital. This was similar to the 12 month period ending July 2015, where 88% of medical staff had received an appraisal.
- There were sufficient numbers of nursing staff in the emergency department (ED) with an up-to-date certificate in emergency resuscitation. Information provided by the trust following our inspection showed to date, 36 staff were trained in paediatric immediate life support (PILS), 39 staff trained in immediate life support

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(ILS), 25 staff trained in advanced life support (ALS) with an additional two booked to attend, 12 staff trained in European paediatric life support (EPLS) and 36 staff trained in trauma immediate life support (TILS).

- Specific training around the care of vulnerable patients for example, patients living with dementia was provided as part of the trust induction and staff were encouraged to access relevant independent courses in their own time if they wished to do so.
- A clinical nurse educator was available in the department and was available to educate and support the training needs and development of nursing staff. The clinical educator and consultant nurse were responsible for ensuring all nurses within the ED had either completed or were working towards completion of ED specific competencies which included for example, competencies in triaging patients and working in the major's area of the department.
- Newly appointed nurses had an induction to their role in the department and had a supernumerary period, the duration of which depended upon their level of experience. We spoke with one newly qualified nurse who told us they had received an appropriate induction in the department and had received a development package from the clinical nurse educator.
- Across the ED there was nine advanced care practitioners (ACPs) and one consultant nurse available to support nursing and medical staff with the assessment and treatment of patients admitted to the department. An additional five ACPs were currently awaiting start dates.
- Nursing staff told us mandatory training was easy to access but they felt there was little opportunity for additional training.
- A revalidation process was in place with good training opportunities for medical staff and nursing staff. The department leader was a 'sign off' for nurses' revalidation with the nursing and midwifery council (NMC).

Multidisciplinary working

- During our inspection we saw an effective multidisciplinary team (MDT) approach to assessing, planning and delivering patient care and treatment; with involvement from all staff within the emergency department (ED). Most staff we spoke with told us there

were good lines of communication and working relationships between the different disciplines. However, two staff told us it was sometimes difficult to identify who the consultant of the day was.

- Staff worked well together to manage the flow of patients through the department. On two occasions during our focussed and unannounced inspections the department had been identified as being under 'extreme pressure'. Despite this, the department was managed efficiently by the nurse in charge who successfully appeared to keep the department calm and minimise risks to patients.
- Medical staff mostly reported good working arrangements with the rest of the hospital, including oncology services, liaison with psychiatric services, children's services, endoscopy and imaging including radiology and pathology. However, concerns were raised regarding delays in referrals to gynaecology and some services at the Pilgrim Hospital.
- A drug and alcohol response team, external to the hospital, was available to provide support to patients and staff between 9am and 5pm, Monday to Friday. Referrals made out of hours would be addressed the next working day.
- Staff told us they received good support from specialist support services within the hospital. For example, acute cardiac (heart) practitioners, the end of life care team, haematology (blood) nurse specialists, the safeguarding team and the specialist team.
- There was daily communication between multidisciplinary teams within the emergency department. Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks and concerns.
- An assertive in-reach team consisting of nurses and allied health professionals was in place in the department to ensure that an effective process was followed when a patient was discharged from the department into the community. Allied health professionals such as occupational therapists and physiotherapists worked within the assertive in-reach team to assist medical and nursing staff with admission avoidance.

Seven-day services

- The emergency department (ED) was consultant led, offering a service 24 hours a day, 365 days a year.

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- The ED had scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography (scan of the heart) and endoscopy. Most staff reported good access to diagnostic services. However, one member of staff told us there were sometimes delays with the reporting of CTs. The trust did not audit access to diagnostic services and were not therefore, able to identify any shortfalls in the service. We were not assured patients would receive diagnostic tests in a timely way.
- The trust did not monitor 'time to first consultant review' to assure themselves that all emergency admissions were seen and had a clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital. However, we reviewed six patient records and saw evidence of a consultant review within 14 hours in five records.
- The ED had timely 24 hour access, seven days a week, to on-site critical care, interventional radiology, interventional endoscopy and emergency general surgery. Staff gave us examples of where they had appropriately accessed these services.
- The minors area of the department was open from 10am to midnight, seven days a week staffed by an emergency nurse practitioner (ENP), a middle grade doctor, one health care assistant (HCA) and a consultant nurse.
- The assessment and ambulatory care unit (AAC) was a nurse-led unit and open 8am to 10:30pm, seven days a week.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- Information and guidance regarding specific policies, procedures or patient conditions was available through the trust intranet.
- There was a formal handover for patients transferred from the department to the wards, which included a summary of the patient's care and treatment in the department. During our inspection we observed the nurse handover of a patient from the emergency department (ED) to the receiving ward.

- Information needed for patients ongoing care was shared appropriately and in a timely way. Discharge letters were created for and sent to GPs following patient attendances. For children an additional letter was sent to relevant children's services...

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing and medical staff demonstrated to us an understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Patients were supported to make decisions and we saw examples where mental capacity assessments had been undertaken. However we saw, where a patient in the department lacked capacity nursing staff had not considered a 'best interests' decision or mental capacity assessment in accordance with legislation. If a person 'lacks capacity' in relation to a matter then other people can make decisions about that matter for them in their 'best interests'.
- The trust monthly emergency department (ED) health check score card for August 2016 showed that 52% of nursing staff were in date with Mental Capacity Act training.
- Medical staff demonstrated to us an understanding of the consent process for children and young people and told us they would refer to the Gillick competency and Fraser guidelines. Gillick competency and Fraser guidelines are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Following our inspection we asked the trust to tell us how many staff had received training on Gillick competency and Fraser guidelines. This information was not provided.

Are urgent and emergency services caring?

Good



The care provided to patients in urgent and emergency services was good because patients were supported, treated with dignity and respect and were involved as partners in their care.

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We found:

- Feedback from patients who use the service and those close to them was mostly positive about the way they had been treated. Patients told us staff were, “courteous”, “respectful” and “kind”.
- We observed nursing and medical staff treating patients with dignity, respect and kindness. Staff spent time talking to patients and showed compassion when patients needed help.
- Results of the CQC A&E Survey (2014) showed the trust performing ‘about the same’ as other trusts.
- Patients were involved and encouraged to be partners in their care and in making decisions. Patients consistently told us they felt involved and understood about their care.
- Patients were supported emotionally and this was reflected in their care and treatment.

However, we also found:

- Some patients and their relatives had concerns about the way staff treated them; feedback on comments cards was mixed with six out of 12 reporting a negative experience whilst in an emergency department (ED) at this trust.
- The NHS Friends and Family Test (FFT) results were worse than the England average.

Compassionate care

- Following our inspection, we reviewed information from 12 comment cards completed by patients and relatives before our inspection. Responses were mixed with six reporting a negative experience whilst in an emergency department (ED) at this trust. We were unable to determine from the comments cards which of the trust’s hospitals the patient or relative had attended.
- In the resuscitation area of ED we used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us. We observed nursing and medical staff treating a patient with dignity, respect and kindness during all interactions. Staff spent time talking to the patient and showed compassion when the patient needed help.
- We spoke with 12 patients and five relatives during our inspection. They were mostly positive regarding the care

provided, they told us they or their relative were cared for in a kind and compassionate manner by staff. Patients told us staff were, “courteous”, “respectful” and “kind”.

- We observed staff consistently taking the time to interact with patients and those close to them in a respectful and considerate manner. Staff showed an encouraging, sensitive and supportive attitude towards patients and their response to patients was compassionate, timely and appropriate.
- Staff carried out regular comfort rounds if a patient was in the department for long periods, we saw these documented in the records we reviewed and saw staff carrying these out during our inspection. Comfort rounds are conducted by staff who visit every patient at set intervals and ask them if they’d like something to drink, or if they’d like to be repositioned or use the bathroom and enquire about their pain.
- We reviewed the NHS Friends and Family Test (FFT) results in the ED from September 2015 to August 2016. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Results showed the average response rate to be 21.3%. This was better than the England average of 13.1% for the same reporting period. Results from this reporting period showed 79.3% of respondents would recommend the NHS service they had received to friends and family who may need similar treatment or care. This was worse than the England average of 86% for the same reporting period.
- The department was part of the ‘counting compliments’ project. The department had commenced auditing the number of compliments and positive patient stories they received each month. Between July and August 2016 the department received 24 compliments. There were 19 positive patient stories for the same reporting period. The ‘counting compliments’ project was reliant on teams counting their thank you cards and gifts.
- The results of the CQC A&E Survey (2014) showed the trust scored ‘about the same’ as other trusts for being given enough privacy when being examined or treated in the A&E department.
- We observed staff treating patients with dignity and respect, staff always drew curtains round cubicles or closed doors whilst examinations were in progress and used blankets to protect patients’ modesty.

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Understanding and involvement of patients and those close to them

- During our inspection, we spoke with seven patients specifically about whether they felt involved and understood about their care. Patients consistently told us they felt involved in their care.
- Throughout the department we observed staff, both medical and nursing, taking the time to ensure patients understood about their care. On a number of occasions we observed staff returning to patients to check their understanding of the treatment they were receiving.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for feeling they had enough time to discuss their health or medical problem with a doctor or nurse, for feeling the doctor or nurse explained their condition and treatment in a way they could understand, for feeling the doctor or nurse listened to what they had to say, for family, or someone else close to them, having enough opportunity to talk to a doctor if they wanted to, for being given the right amount of information about their condition or treatment and for being involved as much as they wanted to be in decisions about their care and treatment.

Emotional support

- We observed staff providing reassurance for patients who were anxious. In the resuscitation area this included a nurse spending time with a patient, the nurse was calm, reassuring and supportive. One patient told us, "The nurse was so sensitive to my vulnerability it made me feel dignified and respected".
- Where young children were upset or frightened teddy bears were available as a means of offering comfort. These were provided for the child to keep. During our unannounced visit to the emergency department (ED) we observed a nurse and a receptionist comforting children through the use of teddy bears.
- Emotional support and information was provided to relatives of patients who were identified as being in the last hours of life or who had passed away in the department. Where a patient had passed away the nurse caring for the patient would arrange to call the relatives back within two weeks as a means of additional emotional support.
- Clinical nurse specialists were available for advice and support in a number of specialties including stroke

services, cardiac services, haematology and end of life care. During our inspection we observed specialist nurses in the department offering emotional support to patients and their relatives.

- Volunteers worked Monday to Friday in the ED. During our inspection we observed volunteers giving appropriate and timely support and information to patients and their relatives.
- Pastoral, spiritual and religious support was available, through the chaplaincy department, to patients, relatives and staff seven days a week in addition to on-call arrangements.

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

Requires improvement



We rated the responsiveness of urgent and emergency services as requires improvement because services did not always meet patients' needs.

We found:

- Some patients were not able to access services for assessment, diagnosis or treatment when they needed to. The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The department achieved this target for 60.6% of the patients who attended the department between September 2015 and August 2016.
- There was insufficient consideration paid to meeting the information and communication needs of patients. The service had not taken steps to meet the requirements of the accessible information standard. However following our inspection the trust told us that a review had been undertaken by the Disability Living Team, with regarding the accessible information standard, but at the time of the inspection the report was still outstanding.
- Staff we spoke with were not aware of a dementia care pathway and 'action cards' available for those patients living with dementia.

However, we also found:

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- Services were planned with commissioners, other providers and relevant stakeholders and delivered in a way that met the needs of the local population. We saw arrangements in place for those patients admitted to the emergency department (ED) with specific conditions requiring time critical interventions and the development of new models of care to address patient flow through the ED.
 - It was easy for patients to complain or raise a concern. Posters and leaflets were available in the ED and these allowed members of the public to identify how they could raise a concern or make a formal complaint. Complaints about the service were shared with staff and appropriate actions taken as a result.
 - The needs of different patients were taken into account when planning and delivering care with for example, good access to Child and Adolescent Mental Health Services (CAHMS) and translation services.
 - There were systems in place to support vulnerable patients and those patients who were medically fit for discharge, with good access to learning disability specialist nurses and the assertive in-reach team (AIR).
 - There was an assessment and ambulatory care unit (AAC) located next to the ED that provided urgent, same day treatment for patients, so that they did not have to be admitted to hospital if there was no requirement for this.
- Service planning and delivery to meet the needs of local people**
- The emergency department (ED) was a receiving centre for major trauma patients but generally only received those patients in 'cardiac arrest'. At which point the patient would be stabilised in the ED before transfer to a regional major trauma centre. The ED had a trauma pathway which provided guidance for staff on the process for stabilising patients prior to transferring them to a regional major trauma centre.
 - Arrangements were in place in the ED for those patients admitted to the department with specific conditions requiring time critical interventions. For example, where a patient was showing signs and symptoms of a stroke the department would be alerted prior to the patient's arrival by the NHS ambulance trust. A specialist stroke consultant and nurse would be present in the department to accept the patient whereupon the patient would receive a computed tomography (CT) scan immediately and be transferred to the specialist stroke unit. Two CT scanners were available adjacent to the department 24 hours a day, seven days a week.
 - The local ambulance service were able to pre alert the department of any sick patient who they were bringing to the department, this ensured staff were able to prioritise the patient on arrival and arrange for the necessary professionals to be ready for the patients arrival.
 - Commissioners, other providers and relevant stakeholders were actively involved in planning services to improve flow within the ED with new models of care being developed. For example, a revised standard operating procedure had been agreed with the local NHS ambulance provider and admission avoidance schemes were being developed in partnership with community services and social care.
 - To improve flow within the ED new models of care had been developed. This involved: Clinicians being assigned areas to work from, rather than selecting the next patient, a new 'major's lounge' where one cubicle was altered to a seating area to accommodate four patients who did not need to be on a trolley and dedicated rapid assessment and treat (RAT) cubicles to ensure an area to assess ambulance patients coming in was always available.
 - The patient waiting area was next to the main reception area. The reception was screened with glass and patients were expected to talk through a specific screen in the glass. The screen sometimes prevented reception staff from hearing what was being said by the patient who would then have to speak louder. The position of the waiting room and the glass partition meant that patient's confidentiality was not always maintained. Reception staff informed us they had displayed a sign informing patients that they could consult with the reception staff in private if they wished to do so. We saw where this information was displayed.
 - There was adequate seating and space in reception and the waiting area; this meant patients did not routinely have to stand while they were waiting to speak to reception staff or for their consultation. A lowered counter was available for patients in wheelchairs in order for them to speak to the reception staff.
- Meeting people's individual needs**

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- Nursing staff in the emergency department (ED) told us they had 24 hour, seven day a week access to Child and Adolescent Mental Health Services (CAHMS) for children and young people who had difficulties with their emotional or behavioural wellbeing. CAHMS was provided by a local NHS mental health trust and would see children in the department or, if admitted overnight, would arrange a telephone call with the child and/or responsible adult. Nursing staff told us this service had improved over the last few months preceding our inspection with fewer admissions to the acute children's ward.
- The ED had access to a language translation service agency that provided a range of interpreting and translation services.
- A wide range of patient information leaflets were available in the department including information on how to raise a concern or complaint. Leaflets were provided in English only but staff told us they could be translated into other languages if required.
- A telephone referral system was in place for staff to access one of two learning disability specialist nurses employed by a neighbouring mental health trust. The trust did not monitor how many patients with a learning disability were accessing services in the ED.
- Information received before our inspection stated a dementia care pathway and 'action cards' were available for guidance to staff on interventions to support patients living with dementia. None of the staff we spoke with could show us this guidance but did tell us they would offer additional support based on the individual needs of each patient. Where vulnerable adults were present in the department, nurse staffing would be adjusted accordingly and information would be communicated through nurse handover.
- A confusion assessment pathway was used to assess elderly patients with an existing dementia diagnosis or to assess delirium or for new / recent issues with memory and confusion. Where applicable we saw this completed in all the patient records we reviewed.
- There were arrangements in place for older people admitted to the department who were medically fit for discharge. Where necessary, patients were referred to the assertive in-reach team (AIR), which was nurse-led and had access to physiotherapists and occupational therapists. The team helped patients return home safely and with support where necessary. The AIR was available in the ED 8am to 8pm, seven days a week.
- Volunteer staff were available in the ED to assist patients and their visitors. We observed the volunteer providing reassurance and making patients feel more comfortable, for example, by offering drinks or magazines and keeping people company. They were also available to sign-post visitors to the cafe, car parks or particular departments.
- Pastoral, spiritual and religious support was available, through the chaplaincy department, to patients, relatives and staff.
- From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the accessible information standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with health and social care services. The service had not taken steps to address this standard. However following our inspection the trust told us. A review had been undertaken by the Disability Living Team, with regarding the accessible information standard, but at the time of the inspection the report was still outstanding.
- A hearing loop system was not available in the reception area. A loop system is a type of sound system that boosts the signal in someone's hearing aids. They help those with hearing loss to focus on particular sounds, like a person talking, near the loop's internal microphone. In conditions without a hearing loop, all sounds including background noise are amplified making it sometimes difficult to focus on one sound.

Access and flow

- The Department of Health target for emergency departments (ED) is to admit, transfer or discharge 95% of patients within four hours of arrival. The department achieved this target for 60.6% of the patients who attended the department between September 2015 and August 2016. During our inspection there had been 38 patients between midnight and 3pm who had been in the ED more than four hours. Of these, seven had been allocated a bed on one of the wards in the hospital.
- For the reporting period September 2015 to August 2016 the percentage of patients in the department for over six hours was 9.5% (6702 out of 70678).

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- The percentage of emergency admissions through the ED who waited between four and 12 hours from the decision to admit until being admitted was less than 3.48% this equated to 664 patients between September 2015 and August 2016.
- Between September 2015 and August 2016 the average time a patient spent in the ED was three hours and six minutes.
- In the period September 2015 to August 2016 the department did not meet the current Department of Health guidelines relating to trolley waits.
- For the reporting period September 2015 to August 2016 the percentage of patients leaving before being seen was 3.3% (2355 out of 70678). This was better than the England average.
- Data for the reporting period January 2016 to June 2016 showed eight patient transfers had occurred after 10pm from the assessment and ambulatory care (AAC) unit at Lincoln County Hospital.
- The ED had an action plan in place, as part of an emergency care recovery programme. 22 actions had been identified with a period for completion of November 2016. We reviewed this action plan following our inspection and saw where a number of actions had been completed. For example, collaborative working with the local NHS ambulance trust, introduction of the rapid assessment and treat (RAT) process, the development and use of an electronic risk tool and the introduction of the flow coordinator role. Where actions had not been completed these were RAG (red, amber, green) rated to determine if they would reach conclusion by the November date.
- The trust was part of the national ambulatory emergency care network. This network supports trusts in developing plans to expand and develop ambulatory care. The trust had established an ambulatory care group who attended the network events and developed plans for the unit. The assessment and ambulatory care unit (AAC) was located next to the ED and provided urgent, same day treatment for patients, so that they did not have to be admitted to hospital if there was no requirement for this. AAC was open daily from 8am to 10.30pm. In the period April to August 2016 the trust had seen a 20% increase in the numbers of patients being admitted to AAC and a 10% decrease in the number of admissions to AAC converting to an overnight stay.
- The ED worked closely with the bed management team to manage the flow of patients through the hospital. A bed meeting took place a minimum of three times a day and was led by the site duty manager. We attended a bed meeting with the matron for ED. During this meeting we saw where bed capacity was reviewed and included for example, the number of patients who had been in the department more than four hours, the number of patients who were ready to be transferred from the ED to a ward, and bed availability throughout the hospital. We saw representation from all specialties to ensure an accurate up to date status of capacity throughout the hospital could be understood.
- During an evening visit to the department ambulances were waiting outside until there was space to bring the patient into the ED. For example, at 9.10pm the department was full, three patients occupied the trolley bay and two ambulances were waiting outside the department. At 10.46pm the department was full, three patients occupied the trolley bay and three ambulances were waiting outside the department. However, we did see effective collaborative team working between the nurse in charge and the local NHS ambulance trust to minimise the risk to patients and manage the flow through the department.
- In a bid to improve patient flow from the ED through the hospital the trust had developed 10 key principles for emergency care. The 10 key principles had been agreed at executive level and were to be rolled out across the trust during October 2016.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for not having to wait long with the ambulance crew before care was handed to A&E, for not spending too long in A&E and for feeling their experience of being treated and cared for in the A&E had been good.

Learning from complaints and concerns

- Between June 2015 and May 2016 a total of 424 complaints were received at Lincoln County Hospital. Of these, 94 related to urgent and emergency services. Senior leads told us the top themes for complaints within this services were communication and delays being seen.
- Complaints relating to the emergency department (ED) were raised through the trust Patient Advice and Liaison Service (PALS) who would make contact with the

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department matron and/or the 'consultant of the day' to investigate. Following investigation of a complaint all relevant staff involved would be made aware of the outcome of the investigation.

- Concerns raised locally in the ED were addressed by the nursing lead who told us delays in treatment or waiting for a bed in the hospital were the main concerns raised. As a result, up to date waiting times were displayed in the department advising the public of how long they could expect to wait to be seen by a member of staff.
- Details regarding individual patient /relative complaints were communicated to staff through a daily brief, email and through the use of a communication book. We reviewed the communication book held within the department and saw where outcomes and learning points from complaints had been recorded.
- Following a complaint regarding a patient's discharge from the ED nursing staff had designed, and were using, a discharge tool 'TRACKS' (T-transport, R-relatives, A-attire, C-cannula, K-keys, S-safe) to facilitate the safe discharge of older and/or vulnerable patients.
- Posters and leaflets were available in the ED. These allowed members of the public to identify how they could raise a concern or make a formal complaint. All the patients and relatives we spoke with knew how to raise a concern or complaint if required.

Are urgent and emergency services well-led?

Requires improvement



We rated the leadership of urgent and emergency services as requires improvement because the leadership, governance and culture did not always support the delivery of high quality patient-centred care.

We found:

- There was not an effective governance framework in place to support the delivery of safe, good quality care.
- Significant risks regarding the provision of services for patients had not been identified by senior nurses and service leads.
- We were not assured incidents were reported and acted upon appropriately. Staff did not routinely raise patient safety incidents for those patients who had not been

appropriately screened or treated for sepsis. This meant there were missed opportunities to address poor compliance in order to minimise the risk of patients being exposed to avoidable harm, when they met the trust criteria for sepsis screening.

- There were low levels of staff satisfaction across all staff groups in the emergency department (ED), in addition to high levels of stress and work overload. Staff were working hard to meet the demands of the service but felt there was little recognition of their efforts. They felt the focus was on performance failings rather than on any positives or their continued efforts.

However, we also found:

- Dedicated staff, medical and nursing, who were committed to delivering high quality, safe care. At times of extreme pressure we saw staff united in managing the flow of attendances through the department.
- The consultant nurse and advanced care practitioners (ACPs) across all three EDs had met to look at how they could develop the workforce throughout urgent and emergency services at this trust. The team were committed to improving services within the ED.
- Staff working on the assessment and ambulatory care unit (AAC) and senior nurses within the ED felt respected and valued by service leads and the wider trust executive team.

Vision and strategy for this service

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

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establishments in the emergency department (ED), the introduction of the 'new emergency care principles' and developing closer working relationships with the frailty team.

- The trust vision; working together to provide sustainable high quality patient-centred care for the people of Lincolnshire was underpinned by five key values; to be patient-centred, safety, excellence, compassion and respect. During our inspection we saw staff demonstrated the trust's values in their day-to-day work, both when caring for patients and their families and when interacting with colleagues. During our focussed and unannounced inspections of the ED we saw dedicated staff, medical and nursing, who were committed to delivering high quality, safe care. At times of extreme pressure we saw staff united in managing the flow through the department.

Governance, risk management and quality measurement

- We did not see an effective governance framework in place to support the delivery of the strategy and good quality care. Significant risks we had identified during our inspection regarding the provision of services for patients with a mental health illness, arrangements for responding to a major incident and the identification, management and treatment of sepsis had not been recognised or raised on the risk register for integrated medicine.
- Service leads did not have a clear oversight of the arrangements in the department for responding to emergencies and major incidents. The NHS has a statutory requirement to plan for and respond to a variety of incidents and emergencies that could affect health or patient care. The Civil Contingencies Act (2004) details that NHS organisations must demonstrate that they can deal with any incident or emergency while maintaining services to patients. In June 2016, NHS England produced a set of updated emergency preparedness, resilience and response (EPRR) core standards. These are the minimum standards which all NHS Trusts must meet. In August 2016, a report had been presented to the public trust board providing the board with assurance of the level of compliance against EPRR core standards. The report suggested United Lincolnshire Hospitals NHS Trust was compliant with 10

of the 11 EPRR standards. Our observations of the departments' arrangements to respond to emergencies and major incidents were not consistent with the content included within this report.

- Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response could be provided by the trust detailing how they were going to address our concerns to minimise risk to patients. In response the trust provided detailed plans outlining actions that were to be taken to address each of our concerns. We saw actions were specific, measurable, achievable, realistic and timely (SMART). As a result we were assured the trust had adequate plans and governance processes in place to address most of our concerns. During our unannounced inspection of the ED the sister told us they now expected all staff to raise a patient safety incident where the assessment and treatment of sepsis had not been managed appropriately and we saw where three such incidents had been raised. However, it was too early for us to be assured this practice would be sustained and actions taken as a result.
- There were inconsistencies between what service leads thought was on the risk register and what we had seen. Service leads told us services for children and young people had been identified as a risk in addition to nurse staffing and overcrowding in the department. We reviewed the risk register for integrated medicine sent to us before our inspection. There were only two risks identified for the ED at this hospital which were; nurse staffing and overcrowding in the department. Both risks were identified in 2014 and we saw where these risks had been regularly reviewed with a recent review of September 2016.
- ED clinical governance meetings were held monthly. We reviewed the minutes of three meetings held before our inspection. Minutes showed where ED performance which included for example, mortality and morbidity reviews, patient experience and evidence-based care had been discussed.
- Metrics for safety and incidents, environment, patient experience, staff experience and nurse staffing were collected monthly to provide an overview of the ED performance. Results were discussed at one to one meetings between the nursing lead and the matron of

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the department and actions or learning points communicated to all other staff in the department through email, the daily brief, during handover and through a communication book.

- There were processes in place, including levels of accountability for the reviewing of all incidents graded as moderate or above with an established three-tier approach in place. The department head of nursing and clinical director met weekly to review all incidents. Incidents would be investigated at a local department level in the first instance, secondly presented to the integrated medicine business unit governance forum and final 'sign off' would be completed at executive level. However, we were not assured incidents were reported appropriately. Trust leads for sepsis told us that would not expect staff to raise an incident where sepsis had not been managed appropriately and that an investigation would only take place if there had been significant harm or a patient had died.
- There had not previously been a forum for discussing incidents or concerns that may have been raised in the emergency departments across the three hospital sites. However, the first 'cross-site' meeting had taken place in July 2016 and further meetings were planned to take place every three months.

Leadership of service

- Urgent and emergency services were provided at this hospital as part of the integrated medicine business unit. The overall lead for the emergency department was the clinical director, who was supported by the senior business manager and the head of nursing.
- Local leadership within the emergency department (ED) was provided by two nursing sisters and a matron. All were working in an 'acting' (not permanent) capacity with the nursing sisters having been in post at this level for five weeks.
- Some staff were frustrated with the "lack of direction" in the department and told us they did not have confidence in the leadership of the ED. They did not feel the team were being given the opportunity to develop. The consultant nurse, from this department, and advanced care practitioners (ACPs) across all three EDs had met to look at how they could develop the workforce throughout urgent and emergency services at

this trust. The team had met for the first time in September and we saw minutes from this meeting demonstrating their commitment to improving services within the ED.

Culture within the service

- Nursing staff told us morale in the emergency department (ED) was low. Staff felt they were working hard to meet the demands of the service with little recognition of their efforts. Whilst leads of the service were proactive in sharing performance outcomes of the department staff considered the focus was on performance failings rather than on any positives or their continued efforts.
- Medical and nursing staff described a 'lack of passion' within the department to improve or change practices. Staff felt when they raised concerns they were not taken seriously with little or no action taken to address concerns. One nurse told us the response they got from a manager was, "what can I do?" Where staff had raised concerns regarding working long hours little action had been taken to avoid this happening again. Nurse staffing had been reviewed in October 2015 but staff told us they had been given no feedback.
- Consultants we spoke with felt the morale of doctors was low due to the current medical staffing rota and the high volume of patients presenting in the department. Medical staff were working long hours, described feeling tired and afraid of making mistakes and felt unsupported by senior managers. Consultants told us they were unsure how long they could sustain the current working arrangements in the department. The trust had recognised and responded to the shortage of medical staff particularly at middle grade level for the ED and a decision had been made to close the Grantham ED at night releasing medical staff to work at Lincoln. Medical staff told us this had increased the number of attendances to ED overnight and increased the medical staff workload.
- Whilst staff understood about candour, openness and honesty when things went wrong, none of the staff we spoke with had received any formal training related to duty of candour.
- Staff working on the assessment and ambulatory care unit (AAC) felt respected and valued, happy to work on the unit and felt part of their immediate team.
- Senior nurses within the ED felt respected and valued by service leads and the wider trust executive team. They

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told us the chief nurse was supportive and visible within the department. The chief executive officer (CEO) had visited the department earlier in the year. This was in addition to regular communication from the CEO through 'weekly blogs' and a monthly newsletter.

Public engagement

- The emergency department (ED) engaged with patients and their relatives to gain feedback from them. Patients were sent text messages to provide feedback. Feedback forms were also available for patients to complete.
- There were posters displayed in the ED to inform patients of the friends and family test. The department displayed their friends and family test scores and a completed friends and family test 'you said we did poster' was displayed.
- Where learning points had been identified as a result of a complaint or patient safety incident, with the patient and/or relatives permission, details were used to form the basis of a teaching session for staff in the department. For example, following the death of a patient in the department their x-rays were used as a training resource.
- Healthwatch Lincolnshire completed 33 'mystery shopper' visits to the Lincoln, Boston and Grantham ED sites, during the period 11 to 29 July 2016. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care.

Staff engagement

- Staff working in the trust were recognised for their contributions to patient care through the United Lincolnshire Hospitals NHS Trust (ULHT) staff awards. Each year, the awards provided a chance to recognise the work, dedication and care given by staff members and teams at the trust. During our inspection we saw where staff in the emergency department (ED) had won a team award in 2015 and had been nominated for two awards in 2016.
- An informal de-brief was held in the ED following any adverse event. For example, a witnessed death, elder or child abuse, and aggression and violence. Staff gave us an example of where this had happened recently following the admission of a child who had sustained a

non-accidental injury (NAI). NAI is a term which is used to refer to many different types of physical injury or abuse. On this occasion nursing, medical and chaplaincy staff had been involved in the de-brief.

- The trust was proactive in their attempts to engage staff in order that staff views were reflected in the planning and delivery of services and in shaping the culture at the trust. The ED had consultant and nurse representation at the trust wide engagement meetings, 'you said-we did' boards were visible in the ED for staff to raise issues, concerns or ideas and staff were encouraged to contribute to a secure social media page. Changes as a result included for example, identifying staff on the nurse rota for where there were to work in the department. This ensured individuals had an opportunity to work throughout the department.
- Locally, the ED had recently (July 2016) conducted an anonymous 'post-it' initiative. This involved staff posting anonymous positive comments about individual members of staff. Named staff would then receive comments related to them.
- A consultant, in the ED, had introduced a comment book for staff to document their experience of the recently introduced rapid assessment and treat (RAT) process.







Innovation, improvement and sustainability

- There was a trust wide 'winter plan' that set out the organisation's arrangements for the winter period. This plan recognised increases in pressure, around winter, due to an increase in the clinical acuity of patients, capacity demands on resources within the trust and untoward events such as widespread infectious diseases including norovirus (sometimes known as winter vomiting bug) and the risk of the onset of pandemic flu. An influenza, or flu, pandemic happens when a new strain of flu virus spreads easily and quickly across the world.
- By working jointly with local commissioners and the health and care community in Lincolnshire the trust had planned a number of schemes and new ways of working at Lincoln County Hospital that would improve capacity. For example, establishing an additional 27- bedded ward for step down patients (patients who are close to discharge), introducing seven-day pharmacy and therapy services and a series of changes to working practices within the emergency department (ED).

Urgent and emergency services

- The trust had an ED risk assessment tool. This was an electronic tool that calculated the risk of the department and rated it as either red amber or green.

Medical care (including older people's care)

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

Information about the service

United Lincolnshire Hospitals NHS Trust provides medical care (including older people's care) at Lincoln County Hospital as part of the integrated medicine business unit.

The trust has 546 inpatient medical beds across Lincoln County Hospital and Pilgrim Hospital, 300 of these beds are located at Lincoln County Hospital. Between March 2015 and February 2016, there were 35,647 medical admissions at Lincoln County Hospital. Emergency admissions accounted for 38.2%. Day case admissions accounted for 58% and the remaining 3.8% were elective admissions.

During our inspection we visited 15 clinical areas, including the medical emergency admissions unit (MEAU), medical emergency short stay unit (MESS), Ashby Ward, Burton Ward, Hatton Ward, Dixon Ward, Carlton-Coleby Ward, Lancaster Ward, Navenby Ward, the stroke unit, Waddington Ward, the coronary care unit, cardiac catheter labs, endoscopy and the discharge lounge.

During our inspection, we spoke with seven patients, two relatives and 69 members of staff. Staff we spoke with included junior and senior medical staff, junior and senior nursing staff, advanced nurse practitioners (ANPs), matrons and health care assistants (HCAs).

As part of our inspection, we used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us understand the experience of people who could not speak with us. We observed interactions between staff, patients, and

patient's relatives, considered the environment and looked at 24 sets of medical and nursing care records. We reviewed 23 patient observation / sepsis screening pathways. Before our inspection, we reviewed performance information from, and about, the trust.

Medical care (including older people's care)

Summary of findings

We rated medical care services as requires improvement overall.

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

- Staff did not always report safety incidents relating to staff being moved to other clinical areas. In addition, staff did not routinely report incidents relating to patients who had not been screened or sufficiently treated for sepsis (a serious and potentially life-threatening condition triggered by an infection or injury).
- There was little evidence across the directorate of sharing lessons learned from incidents.
- Where patients had met the trust's criteria for sepsis screening, not all patients were screened or received treatment in accordance with national guidance. This meant there were times when patients did not receive their intravenous antibiotics within an hour and this increased their risk of harm and increased the possibility of death.
- There had been no risk assessment undertaken within the medical emergency admissions unit (MEAU) or Dixon Ward to identify potential ligature points and to minimise potential risk to patients. In addition, at the time of our inspection, there were no ligature cutters on the MEAU or Dixon Ward, although we saw evidence that ligature cutters were on order for the MEAU.
- We were concerned about the safety of patients should an emergency arise in the overcrowded oncology day unit.
- Staff had not always appropriately updated hydration records to minimise the risk of harm to patients.
- There had been a lack of oversight in relation to the safe handling of medication within the cardiac catheter laboratories.
- Medical and nursing care records were paper-based and on all wards were stored in unlocked notes trolleys in the main ward corridors.
- Patients were not always protected from avoidable harm because medical and nursing staffing levels and skill mix were not appropriate at all times; especially out of hours.
- At times, staff focused on the task instead of the patients as individuals. Staff were providing one to one support for some patients as they had been assessed as being at increased risk. However, when providing one to one support, staff did not always engage with patients meaningfully.
- Nursing care records included care plans for pain, a 'pain assessment in advanced dementia (PAINAD) tool' was available for patients who could not verbalise and/or may have a cognitive disorder. However, the use of this tool was not consistent across the medical directorate.
- Fluid balance charts were not always completed when they should have been.
- The trust had not informed the Care Quality Commission (CQC) about any Deprivation of Liberty Safeguards (DoLS) applications between September 2015 and September 2016. This meant the trust had not been reporting these applications in line with Regulation 18 of the Health and Social Care Act 2008 (Registrations) Regulations 2014.
- Dixon Ward was a locked ward, which meant that patients were not able to leave the ward of their own free will. Patients relied on a member of staff to enable them to leave the ward – the member of staff could make a judgement as to whether the patient was able to leave the ward or not – the ward provided care for patients who had attempted suicide – these patients were under close supervision and were not free to leave the ward – yet they did not have a mental capacity assessment or a DoLS in place.
- There was no clear vision or strategy for the future provision of medical care services throughout the trust. Following our inspection the trust told us that there was extensive systems in place that evidence

Medical care (including older people's care)

that the clinical strategy was communicated to staff demonstrating that the trust had a clear vision and strategy for all services including medicine. We did not corroborate this at our inspection.

- Staff were not aware of a vision or strategy for the future provision of medical care services at this hospital. For example, the arrangements for responding to a major incident, the lack of arrangements relating to the assessment of ligature points and the issues associated with the recognition, management and treatment of sepsis.
- Service leads were not always known to staff and staff told us the leads were frequently changing.
- Although staff felt supported by leaders at a local level, they did not always feel supported by the senior leadership team.
- Staff reported a culture of bullying and intimidation within some medical care services.

However, we also found:

- Resuscitation and emergency equipment checklists had been completed to indicate the equipment had been checked daily by staff and was safe and ready for use in an emergency.
- Patients were protected from abuse; staff had an understanding of how to protect patients from abuse. Staff could describe what safeguarding was and the process to refer concerns.
- Staff were compliant with some of the trust's infection control policies and protocols such as hand hygiene and bare below elbow policies.
- Patient's care and treatment was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to National Institute for Health and Care Excellence (NICE) quality standards.
- Where outcomes for patients were below expectations when compared with similar services we saw where action plans had been put in place.
- During our inspection, we saw a number of care bundles in place. Examples included; neutropenic

sepsis, hyperkalaemia (raised amount of potassium found in the blood), community acquired pneumonia, chronic obstructive pulmonary disease (COPD) discharge, sepsis and urinary catheters.

- Endoscopy services at this hospital were Joint Advisory Group (JAG) accredited.
- Staff were supported to gain competencies to support them in undertaking their roles.
- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient care and treatment; with involvement from general nurses, medical staff, allied health professionals (AHPs) and specialist nurses. All staff we spoke with told us there were good lines of communication and working relationships between the different disciplines.
- A consultant-led system for managing acute (sudden) gastrointestinal (GI) bleeds was available 24 hours a day, seven days a week at this hospital. At weekends, an on-call GI bleed consultant had a dedicated list every Saturday morning for emergency cases and was available throughout the weekends to treat patients experiencing an acute GI bleed.
- Staff had some understanding of the Mental Capacity Act (MCA) 2005 and consent. We saw consent to care and treatment was mostly obtained in line with legislation and guidance, including the MCA and patients were supported to make decisions.
- Staff responded compassionately when patients required help and supported patients emotionally.
- Staff interacted positively with patients and we observed that patients were treated with kindness, dignity, respect and compassion while they receive care and treatment. Feedback from patients was mostly positive about the care and treatment they had received.
- The trust had introduced a carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carer's badge encouraged carer involvement, particularly for patients with additional support needs.

Medical care (including older people's care)

- Staff valued leadership at a local level and staff at ward level told us they felt supported by their ward sisters.

Are medical care services safe?

Requires improvement



We rated the safety of medical services as requires improvement because:

- Staff did not always report safety incidents relating to staff being moved to other clinical areas. In addition, staff did not routinely report incidents relating to patients who had not been screened or sufficiently treated for sepsis (a serious and potentially life-threatening condition triggered by an infection or injury).
- There was little evidence across the directorate of sharing lessons learned from incidents.
- Where patients had met the trust's criteria for sepsis screening, not all patients were screened or received treatment in accordance with national guidance. This meant there were times when patients did not receive their intravenous antibiotics within an hour and this increased their risk of harm and increased the possibility of death.
- There had been no risk assessment undertaken within the medical emergency admissions unit (MEAU) or Dixon Ward to identify potential ligature points and to minimise potential risk to patients. In addition, at the time of our inspection, there were no ligature cutters on the MEAU or Dixon Ward, although we saw evidence that ligature cutters were on order for the MEAU.
- We were concerned about the safety of patients should an emergency arise in the overcrowded oncology day unit.
- Records to demonstrate hourly rounding were not always completed.
- There had been a lack of oversight in relation to the safe handling of medication within the cardiac catheter laboratories.
- Medical and nursing care records were paper-based and on all wards were stored in unlocked notes trolleys in the main ward corridors.
- Patients were not always protected from avoidable harm because medical and nursing staffing levels and skill mix were not appropriate at all times; especially out of hours.

Medical care (including older people's care)

However, we also found:

- Resuscitation and emergency equipment checklists had been completed to indicate the equipment had been checked daily by staff and was safe and ready for use in an emergency.
- Patients were protected from abuse; staff had an understanding of how to protect patients from abuse. Staff could describe what safeguarding was and the process to refer concerns.
- Staff were compliant with some of the trust's infection control policies and protocols such as hand hygiene and bare below elbows policies.

Incidents

- A risk management reporting policy, which was due for review 24 October 2016, included the incident grading system and external and internal reporting requirements, was available to staff. There was a requirement for staff to report incidents, accidents and near misses through the trust's electronic reporting system.
- All staff we spoke with told us they were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system. Agency nurses could not access the trust's electronic reporting system to report incidents and relied on substantive staff to do this.
- However, staff did not always report safety concerns or incidents when they should have done. For example, staff did not report incidences of when staff were moved to other ward areas. This happened frequently throughout the hospital and had the potential to impact on patient care. Staff on the stroke unit were frequently moved to other wards because they were well staffed. However, the staffing levels were planned to cover the eventuality of a nurse attending the emergency department to assess and treat patients experiencing a stroke. In addition, staff on the stroke unit did not incident report times when breaches had occurred because hyper acute ring fenced beds had been used for patients who were outliers. Outliers are patients admitted to hospital who are accommodated on the another ward required due to the lack of availability of beds in the specialty required. A hyper acute ring fenced bed is a bed that is protected for patients who are in the first six hours of experiencing a stroke.
- Staff did not routinely report patient safety incidents relating to patients who had not been screened or sufficiently treated for sepsis (a serious and potentially life-threatening condition triggered by an infection or injury).
- Staff were confident in reporting medication errors and a consistent approach to reporting and sharing medication related incidents was described.
- Staff told us they did not always receive feedback from incidents they had reported.
- Between August 2015 and July 2016, there had been no reported never events in medical care services at this hospital. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Medical services at this hospital reported 2925 incidents from July 2015 and June 2016. Of these, six resulted in death, 60 resulted in severe harm, 231 in moderate harm, 484 in low harm and the majority, 2144 in no harm or injury.
- The most frequently reported incident categories were 809 reports for slips, trips and falls, 515 related to medication, 137 reported as lack of suitably trained staff, 125 incidents reported for abusive behaviour of staff by patients and pressure ulcers, which resulted in 105 reports.
- Of the 2925 incidents, none were reported as near misses. A near miss is an unplanned event that did not result in injury, illness, or damage, but had the potential to do so.
- In accordance with the Serious Incident Framework 2015, the medical care directorate reported 43 serious incidents (SIs) which met the reporting criteria set by NHS England during August 2015 and July 2016 of these, the most common type of incident reported was pressure ulcers; and slips trips and falls both with 18 incidents each. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Medical care (including older people's care)

- Mortality and morbidity meetings were held monthly across all medical specialties to discuss patient deaths. Mortality and morbidity meetings give health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. The trust's mortality review assurance group (MoRAG) further reviewed 10% of all mortality and morbidity reviews. We reviewed minutes from the MoRAG meetings for April 2016, May 2016 and June 2016 and found each review detailed any issues flagged by the MoRAG review and where applicable any actions required to be taken forward.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- We spoke to staff about their understanding of the duty of candour. Whilst senior staff could explain to us that duty of candour was concerned with the importance of being open, honest, and offering an apology when things went wrong; junior staff were not as familiar with the requirements of the duty of candour.

Safety thermometer

- The hospital participated in the national safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas for example, falls with harms, catheter associated urinary tract infections, pressure damage and venous thromboembolism (VTE). VTE is the formation of blood clots in the vein.
- Data between October 2015 and October 2016 showed there had been 57 pressure ulcers, 62 falls with harm and 13 catheter urinary tract infections at this hospital.
- Safety thermometer data was publicly displayed on safety boards throughout the wards we visited. This meant patients and the public could see how the ward was performing in relation to patient safety.

Cleanliness, infection control and hygiene

- The Department of Health's Code of Practice on the prevention and control of infections and related guidance was mostly adhered to within the wards providing medical care.

- We saw equipment was clean and identified as clean and ready for use with the 'I am clean' stickers dated and signed appropriately. Equipment was stored appropriately and clean equipment was clearly segregated from dirty equipment.
- Single use hand wipes were available on meal trays to allow patients the choice to clean their hands prior to eating.
- Where it was suspected a patient had an infection, they were cared for in side rooms with signage to alert staff and visitors of the risk of infection.
- Staff were compliant with the trust's infection control policies and protocols such as hand hygiene and bare below elbows policies.
- Staff mostly demonstrated a good understanding of infection prevention and control. There were supplies of personal protective equipment (PPE) such as gloves and aprons available in clinical areas and we observed staff using them appropriately. Staff wore visibly clean uniforms. However, at our unannounced visit, we observed a member of administrative staff assisting with making a bed and they did not wear PPE. A sister on the ward told us this staff member might also assist in giving out hot drinks to patients. This was not best practice in relation to infection prevention and control and increased the risk of spreading infections.
- All ward and clinical areas had hand cleansing gel dispensers at their entrances and by each patient bed space. Appropriate signage regarding hand washing for staff and visitors was on display.
- Compliance with hand hygiene was audited to measure compliance with the World Health Organisation's (WHO) 'Five Moments for Hand Hygiene'. These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. A review of the audit results from January 2016 to June 2016 demonstrated between 93% and 100% compliance. However the audit was not undertaken every month for each of the Ward areas. Dixon Ward had no results recorded between February 2016 and June 2016.
- Overall, we found the medical care wards at the hospital were visibly clean.

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- Staff in the endoscopy suite followed appropriate decontamination procedures for cleaning endoscopes after use. However, at the time of our inspection, the drying cabinet in the endoscopy suite was broken. This had been reported.
- On the ward areas we inspected, privacy curtains around bed spaces were disposable and all identified the date they were replaced. However, there was no date to indicate when the curtains should be replaced. Staff told us they would be replaced when they became soiled or when they had been in place for six months. In the endoscopy unit, there was no specific labelling and indication for changing curtains. There was a form for staff to complete to record when the curtains had been changed; however, this had not been completed. We were therefore not assured that curtains in endoscopy were always changed when they should have been.
- Trust wide there had been 60 cases of clostridium difficile (*C. difficile*) infections between July 2015 and June 2016. We asked the trust how many cases of *C. difficile* had occurred in the division of medicine. The trust was unable to tell us. *C. difficile* is an infective bacterium that causes diarrhoea, and can make patients very ill.
- Meticillin Resistant *Staphylococcus Aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between July 2015 and June 2016, there were no cases of MRSA reported at this trust.
- Meticillin Sensitive *Staphylococcus Aureus* (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between July 2015 and June 2016 there were 35 recorded cases of MSSA at this trust. We asked the trust how many cases of MSSA had been reported within the division of medicine. The trust was unable to tell us.

Environment and equipment

- Resuscitation and emergency equipment for adults was available on all of the medical wards we inspected. The resuscitation equipment we checked was clean. Single-use items were sealed and in date, and emergency equipment had been serviced. Resuscitation and emergency equipment checklists had been completed to indicate the equipment had been checked daily by staff and was safe and ready for use in an emergency.
- There were systems to maintain and service equipment as required. Equipment was maintained and checked regularly to ensure it continued to be safe to use. Hoists

had been serviced regularly. Where electrical testing had been completed, we saw labelling on equipment to show when testing had been undertaken. All of the equipment we looked at was in date for its testing period.

- We looked at 52 pieces of equipment used for patient care, including manual handling equipment, infusion pumps, suction tubing, mattresses and monitors. We found the majority of equipment had been safety tested and maintained. However, on the endoscopy unit we found six out of 17 suction units should have been safety tested in February 2015 and at the time of our inspection were eight months past their test date.
- The discharge lounge was based on Dixon Ward which was a locked ward caring for patients with disorders of the digestive system and medically supervised treatments for patients with alcohol addiction. The discharge lounge was accessed by an intercom system. The discharge lounge had a fire exit, which could be opened from the inside and was not alarmed. This led to a courtyard, which meant patients from Dixon Ward could exit the ward through this door without staff being aware.
- At our unannounced inspection, we spoke with the senior sister and staff about potential ligature points within the medical emergency assessment unit (MEAU). A ligature point is any point that could be used to attach any piece of material such as a belt or rope for the purpose of strangulation or hanging. We saw a number of areas that could be used for this purpose on the MEAU, including hooks on the wall in the toilets and a large hook outside the staff room in the corridor area of the unit. Staff had limited knowledge relating to ligature risks and were unsure about what ligature cutters were used for. Ligature cutters are specially designed to ensure a safe method of cutting a ligature, which is attached to a person. There had been no risk assessment undertaken within the EMAU to identify potential ligature points and to minimise potential risk to patients. In addition, at the time of our inspection, there were no ligature cutters on the MEAU, although we saw evidence that ligature cutters were on order. We wrote to the trust notifying them of our concerns and requesting a response from the trust to indicate how they were going to address our concerns to minimise risks to patients. In response, the trust provided an action plan outlining the actions they were going to take to address our concerns.

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- We spoke with the matron and staff about potential ligature points within Dixon Ward because there were times when staff on this ward provided care for some patients who had attempted, and continued to be at risk of committing suicide. We found staff had limited knowledge relating to ligature risks. There had been no risk assessment undertaken within Dixon Ward to identify potential ligature risks to patients and there were no ligature cutters on this ward. The matron told us there had recently been a discussion about ligature risks following our announced inspection and the trust was addressing this.
- There was an oncology day unit at this hospital. The unit was overcrowded and we were concerned about the safety of patients in an emergency. We raised our concerns with the sister on the unit who shared similar concerns. The issues had been raised at the monthly unit meetings, however nothing had been done to address the problem. Following our inspection the trust told us the Business unit and senior team were underway with a plan to refurbish this area and increase the footprint. In the meantime, the department would be carefully managing the available space and reserving dedicated spaces for dealing with emergencies should they arise, or assessments where there was a need for privacy.

Medicines

- We looked at the prescription and medicine administration records for 22 patients across nine medical wards. Arrangements were in place for clearly recording the administration of medicines although we identified some omitted doses with no reason for omissions recorded. These included time critical medicines such as anticoagulants, antibiotics and anti-epileptic medicines.
- If people were allergic to any medicines, the prescriber had recorded this on their medication administration record and their wristband.
- Nurses were responsible for educating patients about their medicines at discharge although patients were often sent to the discharge lounge to await their medicines; so, for these patients, this opportunity was lost.
- There had been some issues relating to medications and patients waiting in the discharge lounge. As we inspected this facility, we were alerted to a patient who had medications ordered but they were not made

available. The patient waited 90 minutes and the transport had arrived to take the patient home. The tablets had been returned to the ward rather than the discharge lounge and the discharge lounge had not been notified. The patient went home and had to request the medication from their GP.

- Medicines, including intravenous (IV) fluids were stored securely and we saw controlled drugs (CDs) were stored and managed in line with legislation. CDs are medicines which have extra security controls over them. They are stored in a separate cupboard and their use recorded in a CD register. In a hospital, CDs are required by law to be checked by two registered nurses.
- Limited shelf life products did not display date of opening or new expiry dates meaning that staff could not be assured these medicines remained safe and effective to use.
- Within the cardiac catheter laboratories, we observed two occasions where a nurse prepared medication into a syringe for later use by the consultant without getting the medication second checked. This is unsafe practice and could increase the risk of a medication error.
- Within the cardiac catheter laboratory, we saw that staff had left the medication keys in the medication cupboard lock and the medication cupboard was unlocked. This meant unauthorised people could access these medications and this increased the risk of medications being stolen, tampered with or used inappropriately. We escalated our concerns to the cardiac catheter laboratory manager who took action to rectify the situation.
- On Johnson Ward, we saw two medicine trolleys that should have been secured to a wall behind the nurses' station but they were not. We raised this with a senior nurse who took action to secure the trolleys to the wall.
- In the endoscopy unit there were two nurses who had taken the responsibility for ordering medication. However a pharmacy technician checked the CDs.
- Not all agency staff had been assessed as competent to administer intravenous medications. Where there was just one permanent member of staff on duty working with agency staff they told us they would often have to administer the intravenous medications. Agency staff that had not been assessed as competent would check these medications. This meant there was a risk agency staff did not know what they were checking which

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increased the risk of medication error. We raised this with senior staff at ward level who told us that if necessary they would ask a nurse from another ward to check intravenous medication.

- Some staff, including doctors, reported not getting enough support from pharmacy staff. There were reports that pharmacy staff were not checking tablets dispensed for patients being discharged.

Records

- Patient care records were in a paper format and included pre-printed core care plans and various risk assessments, for example related to venous thromboembolism (VTE), falls, malnutrition, moving and handling, bedrails, and pressure ulcers. Pre-printed care plans were not always individualised to each patient's care needs.
- Patient records were multidisciplinary and nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech and language therapists (SALT) and dietetic staff had made entries.
- We reviewed 25 sets of patient care records across medical services at this hospital and found a variation in their completeness and legibility. However, we did see that where appropriate, entries were dated and signed by the appropriate doctor.
- On the medical emergency assessment unit (MEAU) we found intentional rounding charts were not being completed as regularly as the chart indicated. For example, one patient should have been repositioned three hourly. On the 8 October 2016, we saw the patient had been repositioned at 4am, then again at 6am. There was then no indication the patient had been repositioned for 13 hours. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs
- On Dixon Ward, we found the intentional rounding sheets had been photocopied, the print was faint and not easy to read. We looked at the records of two patients on this ward and found the intentional rounding sheets were not consistently completed. One patient had been admitted on 6 October 2016. We found the intentional rounding sheet had not been completed on this date. On 7 October 2016, the sheet was completed at 7am, 8am and 9 am. On 8 October 2016, the sheet was completed at 1am, 2am, 10am and 12pm and on 9 October; the sheet was completed at 9am and 10 am. Staff had not completed the sheet at all on 10 October 2016. The second patient's intentional rounding chart had not been completed on 6 October or 7 October and on 8 October had been completed at 1am, 2am, 3am, 4am, 8am, 11am, 1pm, 6pm and was incomplete after that. We were therefore not assured patients were always receiving intentional rounding when they should have been.
- Senior staff told us that fluid balance charts and intentional rounding charts were getting better, but they were not always completed as robustly as they should be and additional work on these was required.
- Patient records were not always well maintained; we found some contained loose-leaf pages that had not been filed. This meant that some records were difficult to look through and there was a risk that some records could be misplaced or lost. In addition, records were not always written in date order.
- Records were stored in notes trolleys in ward areas. These trolleys were not locked. We observed unlocked and unsupervised trolleys of patient records throughout all of the medical wards. Although nursing staff told us they were usually around, these trolleys were at times left unsupervised and this increased the risk of them being accessed by unauthorised persons. However, this system ensured health care professionals could access the records at all times.
- During our announced inspection, on Dixon Ward, we observed a computer screen had been left unattended. A member of the inspection team was able to access this information unchallenged.
- During our unannounced visit to the Medical Emergency Assessment Unit (MEAU), we observed two separate instances where junior doctors left their log in cards logged into the computer system. On both occasions, patient identifiable information was on view and could have been accessed or tampered with by people who were not authorised to do so. On one occasion, the doctor had left the unit to see a patient in the emergency department. We took the log in card from the computer and located the doctor to reunite them with their log in card. We spoke with both doctors about the implications of their actions. Both had received information governance training and told us they realised this was not good practice. We escalated our concerns to the consultant on the unit. The doctors told us the reason the smart cards were left in the computer

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was that they were busy and had forgotten to remove them and log out. We could see the doctors were busy. We were therefore not assured that patient identifiable information was as secure as it should have been.

Safeguarding

- The trust had a safeguarding adult's policy (review 2019) and a safeguarding children and young people policy (review September 2016).
- The Chief Nurse was the executive lead for safeguarding, and was supported by the deputy Chief Nurse. There was a named lead for safeguarding adults who was supported by a safeguarding practitioner. All staff we spoke with were aware of the safeguarding leads and none reported any issues accessing the safeguarding leads for support or advice.
- Staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns.
- A framework for mandatory reporting was in place to safeguard patients or children with, or at risk of, female genital mutilation (FGM). Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.
- There were safeguarding link nurses identified on the ward areas whose aim was to up-date and support staff with regard to safeguarding processes and information.
- Safeguarding training was mandatory throughout the trust. As of 31 August 2016, training compliance for medical and nursing staff for level 2 safeguarding adults was 76% and for level 2 safeguarding children was 76%. This did not meet the trust's target of 95% completion for safeguarding training.

Mandatory training

- Mandatory training for all staff groups included; fire safety training, moving and handling, infection control, equality, diversity and human rights, information governance, safeguarding children (level one to three), risk awareness, safeguarding adults (level one to three), health and safety, basic life support and slips, trips and falls.
- The trust target for mandatory training was 95%. Information received before our inspection showed completion rates as at 31 August 2016 for staff across the medical wards was below the trust target in all areas apart from equality, diversity and human rights where

96% of nurses had completed this training. As at 31 August 2016, completion rates for medical staff were, fire safety 73%; infection control 76%; equality, diversity and human rights 90%; information governance 84%; health and safety 82%; slips, trips and falls 81%; moving and handling 79%; risk awareness 82%; fraud awareness 81% and basic life support 31%. For the same reporting period completion rates for nursing staff were; fire safety 71%, infection control 74%, equality, diversity and human rights 96%, information governance 79%, health and safety 87%, slips, trips and falls 90%, moving and handling 84%, risk awareness 83%, fraud awareness 84% and basic life support 43%.

- Mandatory training was accessed either through e-learning or, for some subjects, face to face. Staff told us it was difficult to access training due to shortages of staff on the wards. Senior staff also told us training would be cancelled at times to ensure wards were adequately staffed.
- Insulin prescribing errors had been identified as a cause for concern on Navenby (diabetes) Ward. There was no mandatory insulin prescribing module offered to doctors at this trust.

Assessing and responding to patient risk

- Nursing handovers occurred at every shift change, during which staff communicated any changes to ensure that actions were taken to minimise any potential risk to patients.
- Data received from the trust demonstrated that between October 2015 and September 2016, between 95.3% and 100% of patients were assessed by a suitably qualified medical practitioner within 30 minutes of arrival and reviewed by a relevant medical consultant within 12 hours. This was mostly in line with the London Quality Standards.
- The trust used a National Early Warning Score (NEWS) to identify deteriorating patients. Staff used the NEWS to record routine physiological observations including blood pressure, temperature, respiratory rate, oxygen saturation levels and heart rate. A score was calculated following each physiological observation, which determined the level of risk of deterioration for each patient.
- Trust guidelines were for all patients with suspected sepsis to receive treatment in line with the 'sepsis six bundle', this means patients receive immediate interventions to increase their survival from sepsis.

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- Patients with a suspected infection or NEWS of five or more were supposed to be screened for sepsis using a sepsis identification checklist and sepsis care bundle. Sepsis is a severe infection, which spreads in the bloodstream and if left untreated can lead to death.
- Patients being treated for sepsis were supposed to be treated in line with the sepsis six care bundle. 'Sepsis six' is simply a bundle of medical interventions designed to reduce the risk of harm and death of patients with sepsis if given within the first hour.
- We asked the trust to provide us with sepsis audit data for March 2016 to September 2016. The trust provided data for May 2016 to September 2016. Following our inspection the trust told us that for the months of March and April 2016 a corporate decision had been made to focus on seven day working and training on the new sepsis bundle, and as such no data was collected for these months. The data we were provided with captured information relating to the sepsis bundle NEWS; whether sepsis bundle actions were undertaken within an hour and whether antibiotics were administered within an hour. The data showed this information had not been collected for all wards, for example, within this timeframe, no data had been collected for Ashby Ward, Johnson Ward and the Stroke Ward and data was incomplete for Burton Ward, Waddington Ward, Navenby Ward, MEAU Short stay Ward, MEAU, Hatton Ward, Dixon Ward, Carlton-Coleby Ward and the cardiac short stay unit. We were therefore not assured the trust had a robust system in place for assessing the effectiveness of sepsis identification and treatment.
- Data the trust did submit was variable and demonstrated that between May 2016 and September 2016 there were several occasions where patients did not receive their antibiotics within one hour.
- During our inspection, we reviewed 23 patient NEWS charts across five wards. Of these 23 patients, we found nine had not triggered a NEWS of five or more and there was no requirement for screening these patients for sepsis. Of the remaining 14 patients, we found that five had been screened for sepsis and had been treated in line with the trust's sepsis protocol. Of the remaining nine patients, we found that seven did not have a sepsis screening tool in their medical records despite having a NEWS of five or more. One patient was already receiving antibiotics and so it was felt a sepsis-screening tool was not required. There was no clear documentation to indicate the plan for this patient. Another patient who had triggered a NEWS of six was not screened because the doctor did not feel the patient had sepsis. Another patient who had triggered a NEWS of 5 had a ceiling level of care and a do not attempt cardiopulmonary resuscitation (DNA CPR) form in place. A further patient who had triggered a five was not screened for sepsis because it was felt that two to three of the NEWS was due to the patient having chronic obstructive pulmonary disease (COPD).
- On 5 October 2016, on Navenby Ward, a patient who had triggered a six on their NEWS was screened for sepsis at 9.30pm yet was not diagnosed with severe sepsis until 11pm. Intravenous antibiotics and intravenous fluids were given at 12.16am; two and a half hours after the initial sepsis screen.
- On 8 October 2016, on Carlton Coleby ward, a patient had triggered a NEWS of seven at 12.30pm. We noted a medical review was not undertaken until 3pm. At 12.35pm, an entry had been made in the patient's nursing documentation, stating, "name is on doctor's to do list, awaiting medical assessment". We raised our concerns about this with the senior nurse on the ward who told us this patient was being cared for by an agency nurse.
- Another patient on the stroke unit had triggered a NEWS of three at 7pm with no clear escalation. The next morning at 7.20am, the patient's NEWS was five. A junior doctor who completed a screen for sepsis saw the patient, but as the patient only had one of the systemic inflammatory response syndrome (SIRS) indicators did not proceed with sepsis treatment. This patient was assessed by a more senior doctor at 9.30am and received a diagnosis of sepsis and the sepsis six bundle was started immediately.
- Staff told us the sepsis bundle was not fit for purpose at night because there were not enough medical staff around to implement it.
- The associate medical director and the quality and safety manager were the overall leads for sepsis throughout the trust. During our inspection, we met with them to discuss their plans to improve sepsis management. There were plans in place to improve performance across wards throughout the trust. This included the roll out of sepsis boxes in all clinical areas and the introduction of a patient group direction (PGD) for an injectable antibiotic. A PGD is a set of instructions, which detail the conditions under which a prescription medicine can be supplied to patients without a

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prescription. A business case had also been made to recruit two full-time sepsis nurses, one of which would be based at this hospital. There was also a plan for the roll-out of an electronic learning package. The quality and safety manager and associate medical director told us they were confident there would be an improvement in sepsis management and treatment within six months of our inspection.

- Following our inspection, we formally wrote to the trust notifying them of our concerns in order that a response could be provided by the trust detailing how they were going to address our concerns to minimise risk to patients. In response, the trust provided a detailed plan outlining actions to be taken.
- A critical care outreach team (CCOT) was available to the wards 24 hours a day, seven days a week. The team worked alongside the nursing and medical teams in critical care and supported ward staff in the detection and management of critically ill and deteriorating patients. The aim of CCOT was to ensure deteriorating patients received appropriate and timely treatment in a suitable area.
- Endoscopy was classified as an outpatient service and therefore was not covered by the CCOT. If a patient deteriorated and became unwell in endoscopy staff would need to ensure the patient was transferred to the emergency department to receive the necessary treatment.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.

Nursing staffing

- Patient acuity and dependency data was collected using a combination of the safer nursing care tool (SNCT) and the Hurst audit tool in conjunction with professional judgement principles. Acuity refers to the level of seriousness of the condition of a patient.
- Matrons and senior nurses reviewed and confirmed the patient acuity and dependency scores for each Ward area at the morning board rounds and throughout their visits to clinical areas. The data was considered alongside staffing and patient information including admissions and discharges undertaken in each of the Ward areas.
- The SNCT was also used to assess the nursing skill mix and the number of staff required for each ward. The goal

was to ensure nurse to patient ratios were one registered nurse to a maximum of eight patients in the day time and one registered nurse to a maximum of 11 patients at night time.

- An operational matron had oversight of all of the medical wards at this hospital and visited each ward daily to assess the level of staffing and to support staff. If staff had concerns about staffing or skill mix, they could liaise with the operational matron.
- Nursing and medical staff raised concerns about staffing levels across the medical wards. Staff told us they were moved around on a regular basis to fill staff shortages on other wards, even though this meant that skill mix on their base ward would be compromised which could also mean their base ward would be left short staffed.
- Not all staff felt confident about working on unfamiliar wards but most understood the need to maintain safe staffing levels across the hospital.
- Like many other hospitals throughout the country, this hospital was reliant on bank and agency nurses to fill shifts that were not covered by permanent staff employed by the trust.
- All of the wards we visited displayed a staff information board, which detailed the daily planned and actual number of staff (registered nurses and healthcare assistants) on each shift. We observed the information on some of the boards to be incorrect because staff had been moved to other areas of the hospital to help on other wards that were short staffed. We heard from staff that this happened frequently and witnessed staff being sent to other wards during our inspection.
- During our inspection, we found staffing levels in most areas were sufficient to deliver safe patient care. However, staff told us they often struggled if a patient required one-to-one support, especially when they had been unable to cover this through the agency as this meant a member of staff already working on the ward would have to provide one-to-one care for the patient.
- The hospital provided acute treatment for patients experiencing a stroke on the acute stroke ward. Staff on the stroke ward told us of their concerns relating to staff arrangements, particularly when thrombolysis trained staff were moved to work on other ward areas. The stroke pathway indicated that for patients coming through the emergency department, a thrombolysis-trained nurse would assess them in the emergency department. The stroke ward was therefore staffed to enable the flexibility of a thrombolysis-trained

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nurse to attend the emergency department as required.

A thrombolysis nurse is a nurse who has received specialist training to administer specialist medication to a patient who is experiencing a stroke due to a blood clot. When staff were moved to other areas of the hospital to fill shortfalls in staffing levels, staff told us this compromised the safety of patients on the stroke ward, especially if a thrombolysis-trained nurse was required to attend the emergency department. Staff from the stroke ward were regularly moved to other ward areas to relieve staff shortages and staff told us of their concerns that insufficient staffing on the stroke ward compromised the safety of highly dependent patients, especially when patients had recently been thrombolysed. At the time of our inspection we were not given any examples of when patient care had been compromised.

- There was one whole time equivalent venous thromboembolism (VTE) nurse trust wide. When this nurse took annual leave, there was no one to cover for them.
- There were 8.3 full time equivalent advanced care practitioners at this hospital.
- Agency and bank staff received a local induction checklist to the ward area, which included the location of emergency equipment, ward orientation and working procedures. The nurse in charge signed this along with the temporary staff member to confirm completion.
- The trust was in the process of commencing an agency/bank nurse engagement package. This included the 'block booking' of agency and bank staff to maintain continuity of patient care and skill mix and an incentivised scheme to earn additional training opportunities within the trust.
- The trust reported that as of 30 June 2016, there should have been 361.9 full time equivalent nurses across the medical wards at this hospital; however, there were 290.2 full time equivalent nurses. As of 30th June 2016, this hospital reported a vacancy rate of 13.2% in medical care; based on 58.8 full time equivalent vacancies.
- The bleep holder contacted each ward area at around 3am every day to obtain an overview of the next day's staffing levels.
- Between April 2015 and March 2016 at this hospital, the average turnover rate was 8.5% throughout the medical wards. This rate was based on 39 full time equivalent nurses leaving the hospital.

- Between April 2015 and March 2016, the sickness rate throughout the medical wards at this hospital was 5.05%. The number of full time equivalent days lost was 5,774.32.
- Between April 2015 and March 2016, bank and agency usage rate throughout the medical wards at this hospital was 19.2%.
- We observed a morning nursing handover between staff on one of the care of the elderly wards. We saw that printed handover sheets were used, which listed patients' conditions and treatment. This took place at the entrance to the bay in which the incoming nurse was responsible. Although the team spoke in a quiet voice, this did increase the likelihood that the handover could be heard by patients in the bay and any person who was passing by. We observed that relevant information was handed over to the incoming staff on a need to know basis.

Medical staffing

- The proportion of consultants and junior doctors reported to be working at the trust throughout the medical wards was higher than the England average. However, the number of registrar doctors at this trust was lower than the England average. This trust averaged at 21% against the England average of 36%.
- The trust reported as of 30 June 2016, this hospital reported a medical vacancy rate of 20.6% throughout medical care. This was based on 16.8 full time equivalent vacancies.
- Between April 2015 and March 2016 at this hospital, the average turnover rate was 69.5% throughout the medical wards. This rate was based on 56 full time equivalent doctors leaving the hospital.
- The sickness rate for the medical wards at this hospital was 0.6%. The number of full time equivalent days lost was 178.
- Between April 2015 and March 2016, this hospital reported a bank and locum usage rate of 21% throughout the medical wards.
- Medical staff told us that medical staffing was not always adequate and raised concerns with us about medical staff shortages. We spoke with a junior doctor who told us they were the most senior doctor on the ward that day. They could contact a consultant if they were concerned, but found it more difficult to obtain support for minor medical advice. Following our

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inspection the trust told us there was consultant cover available, and support was available from the middle grade and specialist nurses. We did not corroborate this during our inspection.

- Consultant cover for medical services was three consultants on the medical emergency admissions unit (MEAU) Monday, Tuesday and Thursday plus on call consultant from 12pm to 9pm. Two consultants on MEAU Wednesdays and Fridays plus on call consultant from 12pm to 9pm
- There was a one resident consultant on MEAU at the weekend from 8am to 6pm plus one from 8am to 12pm.
- There were consultants for the following specialities on call 24 hours a day 7 days a week, cardiology, renal, stroke and gastroenterology.
- A FY1 doctor (junior doctor) provided cover for the medical and surgical wards out of hours between the hours of 8pm and 8am. The junior doctor was supported by the hospital at night team and if required could seek guidance from a medical registrar and a surgical registrar. The FY1 also had the support of an orthopaedic FY2 but the FY1 was unaware of this.
- Medical handover took place three times a day, seven days a week between the oncoming and outgoing staff. We observed an early morning medical handover on the MEAU. This was undertaken in private and relevant information was handed over. The handover was also used as an opportunity to communicate any relevant updates.

Major incident awareness and training

- During our unannounced inspection, we found the major incident folder on the medical emergency assessment unit (MEAU) to be out of date. This included the major incident plan (review 2005), staff contact list (2008) and action cards (2005). The major incident folder also contained an out of date policy, which was not in page order. There was a list of contact numbers in the folder but we could not ascertain whether the contact details were up-to-date. One of the senior sisters told us the contact list had recently been updated. We spoke with staff on the unit about the contact list and one staff member told us they were not aware they were on the contact list. This staff member was a bank nurse and their landline telephone details were incorrect.

- The short stay unit folder for major incident planning contained the most up-to-date policy but did not contain an up-to-date list of staff telephone numbers. The senior sister told us this was a work in progress.
- None of the staff we spoke with had received any training on major incident awareness or planning, however, staff we spoke with demonstrated an awareness of where to locate the major incident plan.

Are medical care services effective?

Good



We rated effectiveness as good because:

- Patient's care and treatment was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to National Institute for Health and Care Excellence (NICE) quality standards.
- Where outcomes for patients were below expectations when compared with similar services we saw action plans had been put in place.
- During our inspection, we saw a number of care bundles in place. Examples included; neutropenic sepsis, hyperkalaemia (raised amount of potassium found in the blood), community acquired pneumonia, chronic obstructive pulmonary disease (COPD) discharge, sepsis and urinary catheters.
- Endoscopy services at this hospital were Joint Advisory Group (JAG) accredited.
- Staff were supported to gain competencies to support teams in undertaking their roles.
- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient care and treatment; with involvement from general nurses, medical staff, allied health professionals (AHPs) and specialist nurses. All staff we spoke with told us there were good lines of communication and working relationships between the different disciplines.
- A consultant-led system for managing acute (sudden) gastrointestinal (GI) bleeds was available 24 hours a day, seven days a week at this hospital. At weekends, an on-call GI bleed consultant had a dedicated list every Saturday morning for emergency cases and was available throughout the weekends to treat patients experiencing an acute GI bleed.

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- Staff had some understanding of the Mental Capacity Act (MCA) 2005 and consent. We saw consent to care and treatment was mostly obtained in line with legislation and guidance, including the MCA and patients were supported to make decisions.

However, we also found:

- Nursing care records included care plans for pain, a 'pain assessment in advanced dementia (PAINAD) tool' was available for patients who could not verbalise and/or may have a cognitive disorder. However, the use of this tool was not consistent across the medical directorate.
- Fluid balance charts were not always completed when they should have been.

Evidence-based care and treatment

- Patients had some of their needs assessed and their care was planned and delivered in line with evidence-based guidance, standards and best practice. For example, best practice was followed in line with the National Institute for Cardiovascular Outcomes Research (NICOR) regarding the national heart failure audit. The sentinel stroke national audit programme (SSNAP) data submitted by the trust audited stroke services against NICE evidence-based standards.
- A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. During our inspection, we saw a number of care bundles in place. Examples included; neutropenic sepsis, hyperkalaemia (raised amount of potassium found in the blood), community acquired pneumonia, chronic obstructive pulmonary disease (COPD) discharge, sepsis and urinary catheters. Chronic obstructive pulmonary disease is a progressive, long-term disease of the lung. Staff we spoke with knew how to access these.
- Staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). A VTE risk assessment tool was being routinely used. However, a review of 22 medicine administration charts identified that on two occasions blood-thinning medication (a treatment to prevent thrombosis (clots) forming) had not been signed for. We could therefore not be sure these patients had received their medication in line with their prescription.
- A confusion assessment pathway was in place, which prompted staff to assess whether there was an existing dementia diagnosis, delirium or issues with memory

and confusion. Each element had actions including conducting referral pathways. The trust had adopted the Edmonton Frailty Score to use throughout the County.

- In April 2016, this hospital had a Joint Advisory Group (JAG) status of 'Assessed: Criteria met'. JAG accreditation is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training.
- A consultant reviewed patients twice daily on the medical emergency assessment unit (MEAU). All patients were seen after admission. Once transferred from the MEAU to a ward area, patients were reviewed by a consultant at least once every 24 hours Monday to Friday. At weekends, a consultant did not routinely review patients unless they were admitted at the weekend, there was concern, or their condition was deteriorating.
- Local audit activity included rapid access chest pain clinic and myocardial infarction in the elderly. There were also a range of local audits undertaken by the trust, which included nutrition, patient observations, medication and tissue viability.
- Generic, pre-printed care plans were in use on the medical wards. These contained pre-printed general instructions on care delivery but did not always reflect patients' individual needs and preferences. The lack of personalisation meant it was not always possible to establish the care needs of each patient from the care plans in place.

Pain relief

- Nursing care records included care plans for pain, a 'pain assessment in advanced dementia (PAINAD) tool' was available for patients who could not verbalise and/or may have a cognitive disorder. However, the use of this tool was not consistent across the medical directorate.
- We observed staff undertaking patient intentional rounding, which included pain assessments. Patient records however did not always reflect that this took place hourly. Especially in the medical emergency assessment unit (MEAU), where staff were providing care for patients who should have been allocated to a ward, but were waiting for a bed, and were also providing acute care for patients who had high acuity needs. Intentional rounding is a structured approach whereby

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nurses conduct checks on patients at set times to assess and manage their fundamental care needs. However, staff did not consistently complete intentional rounding charts hourly.

Nutrition and hydration

- A nationally recognised screening tool was used throughout medicine to identify patients, who were malnourished or at risk of malnutrition. Staff used this tool to inform care planning and identify any specific dietary requirements.
- There was a pre-printed care plan for swallowing and nutrition and this was completed as required for each patient.
- Fluid balance charts were used to monitor patients' fluid intake and output. We reviewed 10 patients requiring fluid balance charts. Out of the 10, five were incomplete. Four of these had not been completed for 48 hours with no indication of discontinuation documented within the patients' care records.
- There were different coloured lids on water jugs and beakers to signify those patients who required additional assistance.
- Protected mealtimes were in place across the medical wards. Protected mealtimes encourage hospitals to stop all non-urgent clinical activity on wards during mealtimes. During this time, patients can expect to eat their meals without interruptions and nursing staff are available to offer help to those who needed it.
- We undertook a lunchtime observation on Lancaster Ward and observed staff assisting patients to eat. However, we observed one health care assistant in one bay, who was assisting two patients to eat at the same time. This meant the health care assistant helped one patient and then left that patient to help another patient. We did observe this member of staff wash their hands between supporting each patient.
- Staff provided jugs of fresh water for all patients who were drinking. We saw that all patients had access to water jugs at the bedside, these were within patient's reach.
- On the stroke unit, specialist trained nurses completed swallowing assessments for patients who had experienced a stroke. Speech and language therapists (SALT) were also available Monday to Friday to complete

swallowing assessments. At weekends and out of hours the specialist registered nurses on the stroke unit completed swallowing assessments to ensure patients were not left without adequate nutrition.

- On Hatton Ward, patients who required support with drinking had jugs of water with red lids on them. This signified to staff that the patient required support.

Patient outcomes

- The trust's Hospital Standardised Mortality Ratio (HSMR) for March 2016 was 97.62. Hospital standardised mortality ratios (HSMRs) are intended as an overall measure of deaths in hospital. High ratios of greater than 100 may suggest potential problems with quality of care.
- The latest published Summary Hospital level Mortality Indicator (SHMI) for January 2015 to December 2015 was 110.99 and within hospital SHMI deaths was a reported 105.4 for the same period. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.
- The trust had been identified as an outlier for sepsis in August 2015. A sepsis outlier is where the trust performs worse than the national average. The trust had a task and finish group and an action plan had been developed to address this.
- The trust submitted data to the sentinel stroke national audit programme (SSNAP) which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. From January 2016 to March 2016 SSNAP scored Lincoln County Hospital A on the scale, where E is the worst grade possible.
- The trust provided a 24 hour stroke thrombolysis service (this is a treatment where medicines are given rapidly to dissolve blood clots in the brain).
- Lincoln County Hospital took part in the 2013/14 myocardial ischaemia national audit project (MINAP). The hospital performed better than the England average for the three indicators. Lincoln County Hospital saw improvements from the 2012/13 audit in two of the indicators.
- Lincoln County Hospital took part in the 2015 National Diabetes Inpatient Audit (NaDIA). Results showed the hospital had three scores better than, and 14 scores

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worse than the England average. The multidisciplinary foot care team (MDFT) saw no patients within 24 hours, which was much worse than the hospital's previous result of 57% and the England average of 58%. The hospital also had a high percentage of management errors. The hospital demonstrated a deteriorating performance against their previous results. We saw the trust had an action plan to address the areas where scores were below the England average.

- The trust took part in the heart failure audit. This hospital's results in the 2014/15 heart failure audit were lower than the England and Wales average for the nine standards. The hospital was much lower than the England average for referral to a heart failure liaison service and for left ventricular systolic dysfunction (LVSD). However, since those results, the trust had taken appropriate action and had employed two heart failure nurses. We were shown up to date evidence to show that at the time of our inspection the trust fully meet the required standards for heart failure. This was an improvement on 2014/15
- Monthly monitoring of dementia screening was undertaken as part of the National Dementia Commissioning for Quality and Innovation (CQUIN). The CQUIN payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. Data for the reporting period July 2016 to September 2016 showed between 96.57% and 99.53% of patients were screened for dementia. We also asked for percentage target set by the commissioners of the service however this was not provided.
- Between March 2015 and February 2016 the average length of stay for medical elective patients at the Lincoln County Hospital was 3.3 days, compared to the England average of 3.9. For medical non-elective patients, the average length of stay was 7.3 days, compared to the England average of 6.7 days.
- Between February 2015 and January 2016, medical patients at this hospital had a lower than expected risk of readmission for non-elective and elective admissions.

Competent staff

- All new staff attended an induction. Staff confirmed they received adequate inductions. Newly appointed staff said their inductions had been planned and delivered well.

- Newly qualified nurses were given a period of preceptorship and support and told us they felt well supported.
- Appraisal rates for nursing staff at this hospital, between July 2015 and July 2016 for haematology and oncology was 49.7%; integrated management medicine 41.1% and medicine 60.5%. This was worse than the previous year and was lower than the trust's target of 95%.
- Some staff within the discharge lounge had never received an appraisal.
- The trust had a revalidation with the nursing and midwifery council (NMC) policy, which was in the process of being ratified.
- Nursing staff working in cardiology rotated between the cardiac short stay unit and Johnson Ward. This enabled them to keep their clinical skills up-to-date.
- Eighty percent of registered nursing staff on Carlton-Coleby Ward were signed off as competent to provide care for patients who had a tracheostomy.
- Sixty nine percent of registered nursing staff on Carlton-Coleby Ward had received training and were signed off as competent to enable them to care for patients requiring non-invasive ventilation (NIV).
- As of 31 October 2016, 61% of frontline staff working in elderly care; 93% of staff working in gastroenterology and 76% of staff working in general medicine had received conflict resolution training.
- Staff on the stroke unit had undertaken thrombolysis training, and there was always a thrombolysis-trained nurse on each shift.
- At this hospital, 19 health care assistants had completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers follow in their daily working life. The minimum standards should be covered as part of induction training of new care workers.
- Volunteers received training to enable them to interact with patients who were independent and to assist with drinks, meals and accompanying patients to their cars.
- Agency staff received training through the agency rather than the trust. This information was passed on to the bank manager who would keep an up-to-date record of agency staff training.
- Staff working on the haematology Ward undertook a chemotherapy competency pack. Staff told us they were expected to complete this at home in their own time.

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Following our inspection the trust told us that there was some self directed learning but the department provided protected time for the vast majority of course content.

- Some members of staff had been supported by the trust to undertake a Master's degree in frailty.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient care and treatment; with involvement from general nurses, medical staff, allied health professionals (AHPs) and specialist nurses. All staff we spoke with told us there were good lines of communication and working relationships between the different disciplines.
- Advanced cardiac practitioners (ACPs) supported medical and nursing staff to assess cardiac patients in the emergency department (ED).
- The cardiac service held monthly meetings with the local emergency ambulance service to discuss pathway delays and to establish ways of working with them to reduce delays.
- There was good MDT working within the cardiology service at this hospital. Nurses, allied healthcare professionals and medical staff worked together to ensure the best care for patients was delivered.
- Trust wide MDT meetings within the cardiac service took place by video link, which enabled staff from all three of the trust's hospital sites to attend. The MDT meetings also included surgeons from neighbouring NHS Trusts.
- We also saw good collaborative MDT working on Ashby Ward. Staff of all disciplines were praising of each other and the input each member of the team had into patient care.
- On the stroke unit, we observed good collaborative working. The staff told us the unit felt like 'one big team'.

Seven-day services

- Access to diagnostics services was provided seven days a week for patients who were acutely unwell, which included endoscopy, computerised tomography (CT) or magnetic resonance imaging (MRI) scans. A CT scan and an MRI scan is a three dimensional X-ray.
- Two cardiac catheter laboratories were available Monday to Friday. One was available from 9am to 5pm, the other was available from 8am to 6pm, and there was an on call service available 24 hours a day, seven days a week.

- Physiotherapists, occupational therapists, dietitians and SALT worked daytime hours Monday to Friday.
- A consultant-led system for managing acute (sudden) gastrointestinal (GI) bleeds was available 24 hours a day, seven days a week at this hospital. However, this was not trust wide. At this hospital, there was an acute GI bleed 'on-call system'. Monday to Friday (9am–5pm) a GI consultant was available to undertake urgent endoscopy where required. Overnight an acute GI bleed consultant was on-call to treat patients who were experiencing an acute GI bleed. An on-call endoscopy nursing team supported this activity. At weekends, an on-call GI bleed consultant had a dedicated list every Saturday morning for emergency cases and was available throughout the weekends to treat patients experiencing an acute GI bleed.
- On the stroke unit, ward rounds took place seven days a week. Consultants were on call out of hours and could reach the hospital within 15 minutes if required. Consultants reviewed hyper acute stroke patients seven days a week.
- There was a frailty team who saw patients in the medical emergency admissions unit (MEAU). The frailty team worked 8am until 4pm Monday to Friday. However, the trust was looking to extend this to a seven day service.
- There was consultant presence on all medical wards five days a week and there was consultant presence seven days a week on Dixon Ward. Information provided by the trust following our inspection, indicated that the general medical consultant saw sick patients, new patients and those who were well enough to be discharged following the ward round on the MEAU.
- Staff on the wards reported that out of hours medical cover was worse at weekends than through the week. Following our inspection the trust told us there was an additional junior doctor in place over this period. We did not corroborate this at the time of our inspection visit.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- Information and guidance relating to specific policies, procedures or patient conditions was available through

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the trust's intranet system. However, agency staff could not access this information. If they required access to a policy or procedure, they were reliant on ward nursing staff to log them into the system.

- An electronic discharge document (EDD) was sent to each patient's GP as they were discharged from the hospital's electronic system.
- Agency staff were unable to access information such as investigation and blood results and relied on substantive members of staff to do this, which meant agency staff may not always have the most up-to-date information about the patients they were providing care and treatment to.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust's target for training on consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was 95% and was incorporated into the safeguarding adults training. As of 31 August 2016 training compliance for medical and non-medical staff for safeguarding adults was 61% and 80% respectively. Latest figure of compliance for MCA training provided by the trust was 76% for October 2016, which still did not meet the trust target of 95%.
- Staff had some understanding of the Mental Capacity Act (MCA) 2005 and consent. We saw consent to care and treatment was mostly obtained in line with legislation and guidance, including the MCA and patients were supported to make decisions.
- Deprivation of Liberty Safeguards (DoLS) are a set of checks that aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests.
- Dixon Ward was a locked ward, which meant that patients were not able to leave the ward of their own free will. Patients relied on a member of staff to enable them to leave the ward – the member of staff could make a judgement as to whether the patient was able to leave the ward or not – the ward provided care for patients who had attempted suicide – these patients were under close supervision and were not free to leave the ward – yet they did not have a MCA or a DoLS in place.
- We observed staff providing one to one care on some of the medical wards, which meant the patient was being monitored and kept safe from harm or risks. However, staff told us they sometimes struggled to get one to one

support for patients who needed this. This meant a member of staff already counted in the staffing numbers would have to provide one to one care if an additional staff member was not available.

- Not all staff felt comfortable undertaking mental capacity assessments or making applications for DoLS. Staff on the stroke Ward and on Hatton Ward told us they did not feel equipped to make DoLS applications, which indicated a need for further training.
- The trust did not have a restraint policy and had not undertaken any audits or reviews relating to restraint between October 2015 and October 2016.
- Do not attempt cardiopulmonary resuscitation (DNA CPR) forms were filed at the front of patients' notes, allowing easy access in an emergency. These were recorded on a standard form with a red border. We looked at six DNA CPR forms at this hospital and found they were mostly completed in a way as to protect patients. Out of the six forms, two patients lacked capacity to make decisions. A mental capacity assessment had been undertaken for these patients. Of the four patients who had capacity to make decisions we saw a discussion had taken place with these patients and where appropriate those who were close to them. However, we noted one omission where the doctor had not written an account of the discussion within the patient's medical records. We escalated this to the nurse in charge of the ward.

Are medical care services caring?

Good



We rated caring as good, because:

- Staff responded compassionately when patients required help and supported patients emotionally.
- Generally staff interacted positively with patients and we observed that patients were treated with kindness, dignity, respect and compassion while they receive care and treatment. Feedback from patients was mostly positive about the care and treatment they had received.

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- The trust had introduced a carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carer's badge encouraged carer involvement, particularly for patients with additional support needs.

However, we also found:

- At times, staff focused on the task instead of the patients as individuals. Staff were providing one to one support for some patients as they had been assessed as being at increased risk. However, when providing one to one support, staff did not always engage with patients meaningfully.

Compassionate care

- Most patients and those who were important to them were positive about the care and treatment they had received on all of the medical and care of the elderly wards we visited.
- Throughout our inspection, we saw numerous examples of staff responding to patients with kindness and compassion.
- We spoke with the family of a patient who was acutely unwell on the stroke ward. They told us they had nothing but praise for the care their relative had received. The nurses could not do enough for them.
- We undertook a short observational framework for inspection (SOFI) on Hatton Ward and discretely observed the care of one person for 33 minutes. We observed positive, enabling interactions during which time the patient was being supported to undertake activities and tasks.
- However, at times, staff focused on the task instead of the patients as individuals. Staff were providing one to one support for some patients as they had been assessed as being at increased risk. However, when providing one to one support, staff did not always engage with patients meaningfully.
- At our unannounced inspection, on the medical emergency assessment unit (MEAU) we observed staff transferring a frail elderly person from a trolley to a set of seated scales. The patient was not wearing slippers and was only wearing a nightgown. This was undertaken in full view of other patients. The patient was then wheeled into a bed space and the privacy curtains were drawn round.
- Between October 2015 and September 2016, this hospital's Friends and Family Test (FFT) average

response rate of 27% was below than the England average of 31%. The lowest average response rate was from Dixon Ward at 19% and the highest response rate was Burton Ward at 62%. Between the same reporting timeframe Burton Ward scored consistently well, with 100% of responses stating they would recommend the service they had received to friends and family who might need similar treatment or care.

- Within the chemotherapy suite we noted conditions were cramped and privacy was not afforded to patients receiving chemotherapy treatment. Apart from a space for young people and a space with a bed for patients who felt unwell there were no privacy curtains to afford the privacy of patients throughout their treatment.
- Some staff told us they would not wish their relatives to be cared for at Lincoln County Hospital because they were concerned about the skill mix on some of the wards.
- We spoke with one relative of a patient who had a learning disability. They raised concerns with us about the lack of compassionate care their relative had received.

Understanding and involvement of patients and those close to them

- Patients told us they generally felt involved in their care.
- The trust had introduced a carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carer's badge encouraged carer involvement, particularly for patients with additional support needs. Being signed up to the carer's badge also gave carers free parking whilst they attended at the hospital.

Emotional support

- Nurses and medical staff throughout the medical wards initially provided emotional support. However, additional support could be obtained from the trust-wide chaplaincy team. The chaplaincy team provided an on call service, which was also available out of hours. They provided support and assistance to patients to contact local spiritual or religious priest or ministers.
- Clinical nurse specialists were available for advice and support in a number of specialties including stroke services, cancer services and for care of the older person.

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- Patients informed us staff tried their best to make the hospital environment as homely as possible and we observed a number of patients had personal belongings with them such as photographs. This was particularly apparent on Ashby Ward, where patients had personalised their individual bed spaces.
- The hospital Macmillan nursing team offered counselling and support to patients and staff on the oncology ward.
- A volunteer from the Alzheimer society attended the ward to offer support to relatives and carers.
- A mental health liaison team was available 24 hours a day seven days a week for support, assistance and information.
- A dementia practitioner was available to talk with and support patients and their carers who are living with dementia.
- Throughout the trust, there was no psychologist support for patients who had experienced a stroke. Staff on the stroke ward told us this service was available in the community, however there was a criteria for patients to be mobile to access this support. This meant there could be some patients who had experienced a stroke who were not able to access the psychological support they required.
- There were a number of ring-fenced beds throughout the hospital and these were at times used for outlying patients if no alternative bed could be found. This increased the risk of a ring-fenced bed not being available if a patient required it.
- During our announced and unannounced inspection at this hospital, medical patients were being outlied because there was no bed available for them in their speciality.
- Delays in obtaining to take out (TTO) prescriptions had been identified as delaying discharges and staff attributed this in part to a sporadic pharmacy service to the wards. In addition, pharmacy staff did not routinely access the electronic discharge documents and this resulted in discrepancies not being identified until medicines had been dispensed.
- The hospital did not have an electronic system to identify patients who were being admitted and were living with dementia or had a learning disability.

However, we also found:

- Stroke services provided timely access to initial assessment, diagnosis or urgent treatment of those patients who may be experiencing a stroke.
- The trust recognised that families and trusted friends had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. The trust had introduced the carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carer's badge encouraged carer involvement, particularly for patients with additional needs.
- Within cardiac services, elective patients who were living with dementia or who had a learning disability were identified at the pre-operative phase in order to enable staff to ensure appropriate support could be put in place. Where patients were identified as living with dementia or a learning disability, relatives were encouraged to stay with the patient where possible.
- Staff could access interpreting services for patients who did not speak or understand English. The service was provided externally and included the provision of British Sign Language.

Are medical care services responsive?

Requires improvement



We rated responsiveness as requires improvement because:

- The trust's referral to treatment time (RTT) for admitted pathways for medical services had been worse than the England overall performance since July 2015. The latest figures for June 2016 showed 67.9% of medical patients were treated within 18 weeks.
- Data provided by the trust between July 2015 and June 2016 showed 56% of patients admitted to medical wards moved ward on one or more occasions.
- Between January 2016 and June 2016 trust data showed that across 14 clinical areas 2,107 bed moves had taken place after 10pm. The medical emergency short stay (MESS) unit moved the most patients in this time frame.

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- Ashby Ward had just introduced visits from pets called a therapy (PAT) dog. PAT is a charity and volunteers from PAT, along with their own pets, visit care organisations to enable patients to interact with them.

Service planning and delivery to meet the needs of local people

- Relatives reported a lack of car parking space and the fact there were not enough disabled parking spaces.
- The trust had invested in redesigning Hatton Ward to ensure it was dementia friendly.
- A transient ischaemic attack (TIA) rapid access clinic was available seven days a week for patients who may have experienced a TIA or mini stroke. Referrals to the clinic were by the patient's own GP or the emergency department.
- In planning services, the directorate appointed a number of specialist nurses and clinical educators across the site to support ward provision and to meet the needs of patients requiring specialist care.
- In planning the acute medical wards, steps had been taken to separate the medical emergency assessment unit (MEAU) and the medical emergency short stay unit (MSSU) to ensure patients were appropriately placed.
- Not every ward area provided a communal day area for patients, for example, Dixon Ward did not have a day room as this had been taken to accommodate a discharge lounge. This meant patients on this ward had no alternative but to remain by their bed space. In addition, there was no dedicated area for private discussions to take place.
- Not all staff had a suitable staff room in which they could take their breaks. Staff on Dixon Ward were allocated a cramped area within a locker room. The locker room was also used to store overnight beds, which were used if a relative wished to stay with their loved one. Staff raised concerns with us about this facility because it was also a shared area in which staff got changed into their uniform. We raised this as a concern with the senior leadership team at the trust.

Access and flow

- Site management meetings took place three times each day at this hospital, where the site duty manager and bed managers discussed and assessed the flow of patients through the hospital.
- Site management meetings were used to identify the number of available beds, patients who needed

admission, were awaiting discharge or were on outlying wards. From this information, the site management team made decisions in relation to patient admissions and supported the discharge of patients to make more beds available.

- Following our inspection, we asked the trust to provide us with information about patients who had been discharged out of hours. The trust told us they did not have an out of hours protocol or policy and did not routinely collect data in relation to patients who were discharged out of hours.
- Staff had access to an operational escalation policy (review 2015) through the staff intranet. The policy supported managers to identify bed capacity issues early. It identified triggers and actions needed to cope with increased demand for services. The policy clearly identified which wards and departments could open up extra beds and the type of staff required to make the ward safe. There were no escalation beds open at the time of our inspection. Escalation beds are beds that are opened when there is no capacity to admit patients within the hospital.
- During our announced and unannounced inspection at this hospital, medical patients were being outlied because there was no bed available for them in their speciality. This was because there was not enough capacity throughout the hospital for patients requiring admission. Medical outliers are patients who receive care on a different speciality ward. The trust had systems in place to monitor medical outliers throughout the hospital. Medical reviews of outliers took place once their consultant had completed the ward round on the ward for which they were responsible.
- At the site management meeting, we asked about the processes in place for outlying patients. Staff at this meeting told us there was a buddy system and wards were paired up. However, staff at ward level told us this did not happen and patients were outlied wherever there was a bed available. A list of patients who had been outlied was produced each day and was taken into account at the site management meeting.
- Throughout our inspection, senior staff told us the trust's outlier policy was being updated. Following our inspection, we asked the trust to share their outlier policy with us. The trust shared this policy with us at the beginning of December 2016. The policy provided guidance for the management of outlying patients and explained the responsibilities of the operations centre in

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monitoring and managing outliers. The policy had been updated in October 2016, but was not version controlled. This meant that staff at ward level might not be certain as to whether they were using the correct version of the policy for guidance.

- There were a number of ring-fenced beds throughout the hospital and these were at times used for outlying patients if no alternative bed could be found. This increased the risk of a ring-fenced bed being available if a patient required it. Ring-fenced beds are protected beds used for a sole purpose. There was a 'hyper acute bed breach book' on the stroke unit, which indicated if a stroke patient was unable to access a stroke bed due to outliers. However, these breaches were not audited. We saw there had been two breaches for October 2016. The trust's outlier policy did not include any information about using ring-fenced beds to outlie patients.
- Patients were admitted to the medical emergency assessment unit (MEAU) from the emergency department, whilst GP referrals went to the ambulatory care unit. There was a strict nurse led criteria for admission to the unit and the MEAU nurse co-ordinator assessed the suitability of the patient for admission to the MEAU. A doctor and a nurse would assess the patient and prescribe an initial plan of care. The consultant aimed to review each patient within 12 hours. The average length of stay on the MEAU was 12 to 24 hours. However at the time of our inspection, there were 26 patients on the unit and 11 of them had been on the unit for longer than 24 hours. One patient had been on the unit for 77 hours. Staff told us that it was difficult to provide the level of care for patients who no longer acutely unwell as well as for patients who were being admitted with acute conditions. We saw this was the case where patients were not being repositioned as frequently as they should have been.
- Stroke medicine provided timely access to initial assessment, diagnosis and urgent treatment of those patients experiencing a stroke. There was a dedicated telephone line, used by paramedics to alert the stroke team of patients who they suspected had experienced a stroke.
- There were 28 beds including four ring fenced 'hyper-acute' beds on the stroke ward at this hospital. Hyper-acute refers to those patients in the early stages of stroke. A consultant and specialist-trained nurses rapidly reviewed any patients experiencing a stroke, including those in the emergency department and those

who may already be an inpatient on another ward.

These nurses followed a rapid assessment protocol to ensure patients received swift treatment on the stroke pathway, including a computerised tomography (CT) scan, thrombolysis and a swallowing assessment. A CT scan is a three dimensional X-ray. Thrombolysis is a treatment used to dissolve dangerous blood clots in blood vessels.

- We discussed out of hours bed transfers with senior staff at the site management meeting. They told us that out of hour's bed transfers were avoided wherever possible. Data provided by the trust for the reporting period January 2016 to June 2016 showed that across 14 clinical areas 2,107 bed moves had taken place after 10pm. The medical emergency short stay (MESS) unit moved the most patients in this period.
- Data provided by the trust for the reporting period July 2015 to June 2016 showed 44% of medical patient admissions did not move wards during their hospital stay. However, 56% of patients moved ward on one or more occasions.
- Between March 2015 and February 2016, the average length of stay for medical elective patients at Lincoln County Hospital was 3.3 days, compared to 3.9 days for the England average. For medical non-elective patients, the average length of stay was 7.3 days, compared to 6.7 for the England average.
- There was a discharge lounge at this hospital which could accommodate 14 seated patients and two patients who required a bed. The discharge lounge was open Monday to Friday, between the hours of 8am and 6pm. There was a daily record sheet, which included details of how long patients had waited and for what reason, if there had been any delays. The sheet was sent to the operations room for information. However, feedback on the outcome of these audits was not shared with the staff in the discharge lounge.
- Most staff throughout the wards told us that discharge planning started as soon as patients were admitted to the wards. However, some staff raised concerns about delayed discharges related to some patients waiting for rehabilitation beds in the community.
- In June 2015, the admitted and non-admitted operational standards were abolished, and the incomplete pathway standard became the sole measure of patients' legal right to start treatment within 18 weeks of referral to consultant-led care. The trust's referral to treatment time (RTT) for admitted pathways for medical

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services had been worse than the England overall performance since October 2015. The latest figures for September 2016 showed 76% of patients were treated within 18 weeks. No specialties were above the England average for admitted RTT (percentage within 18 weeks). The specialties of cardiology, dermatology; gastroenterology, general medicine, elderly care medicine, neurology, rheumatology and thoracic medicine were all below the England average for admitted RTT.

- Bed occupancy information was requested for medical services at Lincoln County hospital; however, a statement provided by the trust demonstrated only trust wide data was collected.
- There was a discharge hub at this hospital that could support wards with the discharge of patients with complex social care needs. Staff on the ward were responsible for planning the discharge of patients who had simple discharge needs. There was a daily meeting in the discharge hub and discharge coordinators had the facility to track patients, feedback to the wards through board rounds and multidisciplinary team (MDT) meetings on the progress of patients with complex needs.
- There was a standard operating procedure in place for the review of patients with a long length of stay (LOS). This was to ensure patients LOS was reviewed at regular intervals with the aim of avoiding delays. Patient's LOS and reasons for this were reviewed every five days.
- Delays in obtaining to take out (TTO) prescriptions had been identified as delaying discharges and staff attributed this in part to a sporadic pharmacy service to the Wards. In addition, pharmacy staff did not routinely access the electronic discharge documents and this resulted in discrepancies not being identified until medicines had been dispensed.

Meeting people's individual needs

- Within cardiac services, elective patients who were living with dementia or who had a learning disability were identified at the pre-operative phase in order to enable staff to ensure appropriate support could be put in place. Where patients were identified as living with dementia or a learning disability, relatives were encouraged to stay with the patient where possible.
- Patient information and advice leaflets were available in English, but we did not see leaflets available in any other language or format. Staff told us they could get

leaflets printed in other languages if they were required. On the medical emergency admission unit (MEAU) we saw leaflets about mealtimes that had been printed in Chinese, Polish and Lithuanian.

- Staff could access interpreting services for patients who did not speak or understand English. The service was provided externally and included the provision of British Sign Language.
- Ashby Ward had just introduced visits from pets called a therapy (PAT) dog. PAT is a charity and volunteers from PAT, along with their own pets, visit care organisations to enable patients to interact with them.
- There was no electronic system in place for identifying patients living with dementia at this hospital. This meant patients living with dementia were not easily identifiable throughout the hospital. However, there was a front door frailty service, which had been developed to enable older frail people admitted to the MEAU to have a comprehensive elderly assessment.
- All emergency admissions of patients over 75 years of age were screened for dementia as part of the admission process and as part of the commissioning for quality and innovation (CQUIN) for confusion assessment. There was one band four dementia practitioner at this hospital who, was responsible for ensuring this information was captured. Once the information for the CQUIN had been captured this enabled the band four dementia practitioner to track where patients living with dementia were and offer support.
- The dementia practitioner received a daily report from information services of all patients who had been admitted to the hospital in the previous 24 hours. They attended admissions wards and visited those aged 75 years and over in line with national screening but also held a caseload of patients living with dementia. The dementia practitioner then visited these patients to offer support, activities and enhanced care. The dementia practitioners reported to the nurse consultant for frailty and clinical educator for complex care.
- The hospital did not have an electronic system to identify patients who had a learning disability. This meant that patients living with a learning disability may not be identified in a timely manner. Two learning disability specialist nurses employed by a neighbouring mental health trust provided liaison support for Lincoln County Hospital. One of the nurses covered Lincoln County Hospital and Louth Hospital. There was an open

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referral system and the nurse carried a mobile telephone so they could be alerted of the patient's admission. Information provided by the trust indicated there was a learning disability care plan, which was instigated by the learning disability nurse specialist on referral. We did not see any patients with a learning disability on the wards we inspected. However, we did receive some feedback from a relative of a patient who had been nursed on Carlton Colby Ward at this hospital. The relative informed us there was no recognition of the patient's needs. This led to the family spending day and night sitting with the patient to ensure their needs were met.

- Within the endoscopy unit, a chaperone service was offered. However, this was not displayed or detailed on the admission sheet. This meant patients would not be aware this service was offered unless a member of staff pointed it out to them.
- On the endoscopy unit we noted no system for flagging patients with a learning disability, however we did note that records did identify patients who had special requirements, for example those with a learning disability or diabetes.
- The trust had a specialist diabetic inpatient service and employed two diabetic nurse specialists who assessed and provided support for patients with diabetes. Information submitted by the trust indicated that patients were empowered to administer their own insulin.
- Staff told us they could get equipment if required for patients who were obese. We saw there were facilities for heavier patients in the endoscopy suite.
- The trust recognised that families and trusted friends had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. The trust had introduced the carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carer's badge encouraged carer involvement, particularly for patients with additional needs. Being signed up to the carer's badge also gave carers free parking whilst they were in attendance at the hospital.
- Hatton Ward was designed to be dementia friendly. Toilet doors had visual signs on them. However, the ward provided 27 beds, which staff felt were too many to provide safe care for patients living with dementia. At the time of our visit, a new Hatton Ward was being developed to provide care for 20 patients. We looked at

this ward and found it was being designed with people who were living with dementia in mind and each bay had a seated area where staff could sit to enable interactions with patients.

- On the care of the elderly wards a red, amber, green system was used to identify patients who required more assistance than others. Red signified those patients who required the most help, whilst green identified those patients who required the least. This system was also applied to each patient's menu card to signify the amount of support a patient required with eating. Patients with a green sticker were given their meals first. Staff who took meals to patients with a red sticker then stayed to support the patient to eat their meal.
- Within the chemotherapy suite, we noted conditions were cramped and privacy was not afforded to patients receiving chemotherapy treatment. Apart from a space for young people and a space with a bed for patients who felt unwell, there were no privacy curtains.

Learning from complaints and concerns

- Monthly complaints reports were shared with the patient experience committee and the quality governance committee. A patient experience report was presented at trust board level.
- Monthly scorecards at site level were provided and a site report was produced which included number of complaints received, number of complaints still open, percentage responded to within timescale, percentage overdue complaints, breakdown of overdue complaints at business unit level and any trends identified.
- Complaints service reviews and performance were discussed at Clinical Executive Committee and Executive team meetings.
- Completed complaints were a standing item on specialty governance meetings.
- Posters and leaflets were available in the wards and clinical areas we visited. These allowed members of the public to identify how they could raise a concern or make a formal complaint.
- A Patient Advisory and Liaison Service (PALS) was available at the trust for members of the public to raise a query or concern, access information or to make a formal complaint about the services provided to them.
- One complaints manager worked trust wide. The complaints manager was responsible for a team on each of the three hospital sites. The complaints manager reported to the deputy chief nurse.

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- There had been 144 complaints relating to medical care services at this hospital between June 2015 And May 2016. The top five subjects for complaints were clinical treatment, communication, patient care, waiting times and issues relating to admission and discharge.
- Ward sisters were involved in investigating complaints in their areas. All staff we spoke with knew how to deal with complaints and concerns. Nursing staff told us they would try to resolve complaints quickly and locally whenever possible. Managers for the appropriate speciality produced action plans and identified learning. Managers shared learning from complaints through team meetings, safety briefings, newsletters and emails.

Are medical care services well-led?

Requires improvement



We rated well-led as requires improvement because:

- There was no clear vision or strategy for the future provision of medical care services throughout the trust. In addition, staff were not aware of a vision or strategy for the future provision of medical care services at this hospital. Following our inspection the trust told us that there was extensive systems in place that evidence that the clinical strategy was communicated to staff demonstrating that the trust had a clear vision and strategy for all services including medicine. We did not corroborate this at our inspection..
- Service leads were not always known to staff and staff told us the leads were frequently changing.
- Although staff felt supported by leaders at a local level, they did not always feel supported by the senior leadership team.
- Staff reported a culture of bullying and intimidation within some medical care services.

However, we also found:

- Staff valued leadership at a local level and staff at ward level told us they felt supported by their ward managers.

Vision and strategy for this service

- The trust had a clinical services strategy for 2016 to 2021. This included reviewing current services, refining the delivery of medical care and meeting the health needs of the local community. However, there was no

clear vision or strategy for the future provision of medical care services throughout the trust. During our meeting with the senior leadership team for medicine, we were told there was no overarching strategy for the integrated medicine business unit, but each speciality had a strategy for its service.

- Staff we spoke with throughout medical care services told us they were not aware of a vision or strategy for the future provision of medical care services at this hospital. Following our inspection the trust told us that there was extensive systems in place that evidence that the clinical strategy was communicated to staff demonstrating that the trust had a clear vision and strategy for all services including medicine. We did not corroborate this at our inspection.

Governance, risk management and quality measurement

- Governance and risk management arrangements were not robust. There was a risk register for the integrated medicine business unit at this hospital. This included 38 open risks in total. Six of these risks related to unsafe nurse staffing levels, one related to inadequate accommodation for the oncology service, one related to a lack of space in the medical outpatient department and another related to a consultant cardiologist who was leaving the trust at the end of November 2016. Concerns we identified during our inspection however, had not been included on the risk register for integrated medicine. Such as the arrangements for responding to a major incident, the lack of arrangements relating to the assessment of ligature points and the issues associated with the recognition, management and treatment of sepsis.
- Each speciality held monthly clinical governance meetings. We reviewed the minutes of meetings held by each speciality before our inspection. There was no set agenda for all specialities to follow, each speciality discussed different topics, and we noted that some minutes were more in-depth and robust than others. Whilst some specialities discussed a breadth of areas such as incidents, complaints and compliments, audit, clinical effectiveness, best practice, risk register, education and training, other specialities clinical governance minutes were very brief.
- The first trust wide business unit meeting for medicine had taken place in July 2016. The meeting provided an opportunity for clinicians from all specialities to come

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together to discuss factors affecting the business unit as well as share learning. The business unit meeting fed into the trust's Quality Performance and Improvement Committee (QPIC), patient safety and clinical effectiveness committee (PSC) and the hospital management group (HMG). These groups fed into the upward report that was presented to the trust's Quality Governance Committee.

- Information was collected throughout the medicine business unit through a safety and quality dashboard (SQD) this included ward performance on falls assessments, Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) forms, physiological observations, sepsis, nutrition, tissue viability and patient dignity.

Leadership of service

- Medical services, including older people's care, were provided at this hospital as part of the integrated medicine business unit. The integrated business unit was split into four clinical directorates. These were:
 - Haematology/oncology and neurology.
 - Diabetes/endocrine, care of the elderly, respiratory, gastroenterology and stroke.
 - Accident and emergency and acute medicine and specialist palliative care.
 - Cardiology and cardiac physiology.
- Some services were managed trust wide, which included oncology, haematology, neurology, and cardiology. Other services were managed locally at Lincoln County hospital, which included care of the elderly, diabetes, respiratory, gastroenterology, acute medicine, and stroke.
- A clinical director led each directorate supported by a senior business manager and a head of nursing.
- The clinical directors felt well supported.
- Band seven ward managers provided local leadership at ward level. The band seven ward managers were supported by a matron within each of the clinical directorate.
- Staff told us they felt supported by staff leading them at a local level but they did not always feel supported by the leadership team above matron level.
- Most staff said they were not aware who the service leads were for medical services throughout this hospital. Staff told us the service leads were always changing.
- Staff on Carlton-Colby ward were very praising of the support they received from their local leadership team.

Culture within the service

- Staff within some of the medical wards at this hospital told us that morale within medical care services at this hospital was low.
- Three members of staff told us they were not encouraged to speak up and whilst talking to us indicated they would not be very well thought of for sharing their concerns with us, whilst other staff told us they were not afraid to speak out and felt they were listened to.
- Three members of staff wanted to meet us in private and tell us of their concerns anonymously.
- Two members of staff shared with us a feeling of intimidation and described a bullying culture when they had tried to raise concerns about patient safety with one of the matrons in the operations room.
- Another staff member told us they had felt intimidated by some members of the leadership team and described examples of where they had tried to raise concerns about patient safety but leaders were dismissive of them.
- One member of staff told us they thought the hospital was safer than it used to be but the leaders didn't always want to hear about things that were not going well.
- We spoke with junior medical staff and consultant medical staff. We received a mixed picture from these groups. Some doctors felt well supported, whereas others felt less supported and felt that more could be done to improve the leadership they received from the clinical directors. However, there was a general consensus amongst doctors that the hospital was safer than it used to be.

Public engagement

- The trust recognised that families and trusted friends had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. The trust had introduced the carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carers badge encouraged carer involvement, particularly for patients with additional needs. Being signed up to the carers badge also gave carers free parking whilst they were in attendance at the hospital.

Staff engagement







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- Staff working at this trust were recognised for their contributions to patient care through the United Lincolnshire Hospitals NHS Trust (ULHT) staff awards. Each year, the awards provided a chance to recognise the work, dedication and care given by staff members and teams at the trust. During our inspection, staff on the stroke unit told us they had been nominated as team of the year for the 2017 awards.
- On Lancaster Ward, there was a morale board in the staff room. Staff used this to pin photographs of team social events.
- On Carlton Colby Ward staff had a 'huddle' at 2pm. This gave staff the chance to receive positive and negative feedback and to give staff the chance to feedback.
- Staff on Hatton Ward told us of a closed 'complex needs' social media group which was available to all staff working on Burton Ward, Hatton Ward and Lancaster Ward. This page contained details related to training and significant events.
- The chief executive sent a weekly email blog to all staff. This included things such as vacancies, what was happening in the trust, information about national visits, award winning staff and health information such as the flu vaccine.
- Staff on Dixon Ward had raised concerns about their staff room facilities, which were cramped and unsuitable for staff to take their breaks. Staff felt they had not been listened to; however, senior staff told us that Dixon Ward was next in line to be refurbished.

Innovation, improvement and sustainability

- Staff on Hatton Ward had received praise from the specialist palliative care team in relation to their involvement with end of life care interventions.

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

Information about the service

United Lincolnshire NHS trust provides a range of surgery and associated services at the Lincoln County Hospital (LCH) as part of Lincoln surgical business unit (SBU). Within the SBU, there are four clinical directorates. These are surgery and urology, orthopaedics, theatres and critical care and head and neck services.

At this hospital, there are 224 inpatient beds across six surgical ward areas (Clayton, Digby, Greetwell, Neustadt-Welton, Shuttleworth, Surgical Emergency Assessment Unit) and 14-day care beds on the Surgical Assessment Lounge. Inpatient services include general surgical specialties, including upper gastrointestinal, colorectal, urology, breast and trauma and orthopaedics. Services for surgical patients are provided through outpatients, the pre-operative assessment unit, and day surgery and inpatient wards.

The surgical division has 11 theatres, two of which are laminar flow (this is a type of air conditioning that reduces air borne infections) including theatres for day case surgery. One theatre is available for emergency surgery 24 hours a day seven days a week.

Between March 2015 and February 2016, there were 19,594 episodes of care. Of these 42% were non-elective (emergency) admissions, 40% were day case procedures, and the remaining 18% were elective (planned admissions). A total of 38.2% of episodes were general surgery, 15.5% were trauma and orthopaedics, 11.2% were ophthalmology, 10.9% urology, 9.1% head and neck and 9.5% were ear nose and throat (ENT).

During our inspection, we visited the pre-operative assessment clinic, day surgery unit, operating theatres, recovery and all six surgical wards.

Before the inspection, we reviewed performance information from and about the trust. During our inspection, we spoke with 30 patients and 10 visiting relatives. We spoke with 75 members of staff, including doctors, nurses, physiotherapists, occupational therapists, health care assistants, trainee doctors and senior managers. We received comments from people who contacted us to tell us about their experiences. We reviewed treatment and care records for 22 patients and observed staff interactions with patients during the course of their activities. We also reviewed the arrangements in place to support the delivery of elective and emergency surgery, including the environment and provision of resources.

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Summary of findings

We rated this service as good because:

- Staff understood their responsibilities to raise concerns and report incidents and near misses.
- Lessons were learned and communicated widely to support improvement. For example, thorough checking of surgical hip or lens implants before use.
- Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies.
- Monitoring and audit of safety systems was robust. There was an effective audit for the World Health Organisation (WHO) five steps to safer surgery checklists.
- There were systems, processes and standard operating procedures in infection prevention control, records, and maintenance of equipment, which were mostly reliable and appropriate to keep patients safe.
- Patients were protected from abuse; staff had an understanding of how to protect patients from abuse.
- Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation and patients received effective care and treatment.
- We saw where patients symptoms of pain were mostly managed in both ward and department areas with good comfort outcomes.
- We observed staff positively interacting with patients and patients were treated with kindness, dignity, respect and compassion while they received care and treatment. Feedback from patients was positive about the care and treatment they had received.
- Surgical care services were responsive to patient's needs; patients could access services in a way and at a time that suited them and there was a proactive approach to understanding and meeting the needs of individual patients and their families.

- The leadership, governance and culture in surgical care services supported the delivery of high quality person-centred care; governance and risk management arrangements were mostly effective and as such able to protect patients from avoidable harm.

However,:

- There were periods of inappropriate skill mix in when staffing the escalation beds in the surgical assessment lounge. Following our inspection the trust told us that risk assessment were undertaken to ascertain the safest ward area to complete the substantive skill mix swap for the escalation area. During our inspection we did not have the opportunity to observe this process.
- There was a lack of consistency in staff understanding of the Mental Capacity Act (2005), the use of mental capacity assessments and Deprivation of Liberty Safeguards (DoLS).
- Medical staff in the head and neck clinical directorate were not always compliant with the trust appraisal process.

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Are surgery services safe?

Good



We rated safe as good because:

- Staff understood their responsibilities to raise concerns and report incidents and near misses.
- Lessons were learned and communicated widely to support improvement. For example, thorough checking of surgical hip or lens implants before use.
- Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. For example, a deteriorating patient on the surgical emergency assessment unit.
- There were effective handovers to ensure risks to patients were identified and managed.

However,:

- Patients preparing for surgery did not always have venous thromboembolism (VTE) assessments completed in a timely manner or reviewed after 24 hours.
- Staff raised concerns about the safety of staffing on the wards when they were moved to the surgical assessment lounge when it was used for overnight escalation.

Incidents

- Between August 2015 and July 2016, one never event had been reported within surgery at the Lincoln County Hospital (LCH). Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- The never event reported in March 2016 related to the insertion of a 32mm ceramic acetabular insert instead of a 36mm insert implanted into the patient's total hip replacement in error. A 36mm head was used thinking

that a 36mm acetabular insert had been implanted. A size miss-match between acetabular insert and femoral head components resulted. (These are all parts used in replacing hip joints).

- The incident investigation for this never event included root cause analysis (RCA). An RCA is a method of problem solving used for identifying the causes of faults or problems. The RCA highlighted incorrect checking of implants during surgical procedures.
- Following this never event the trust implemented a new checking procedure to ensure three separate members of the surgical team checked implants at three stages of the procedure.
- During our inspection, theatre staff told us about this procedure and we saw the checks taking place. An implant was first checked whilst setting up the operating equipment. The scrub practitioner then checked the implant and verbally repeated the information to the surgeon who again checked it and verbalised the checks prior to implantation. This was then recorded in the operation documentation.
- In accordance with the Serious Incident Framework 2015, the surgery directorate for this trust reported 12 serious incidents (SIs) which met the reporting criteria set by NHS England during August 2015 and July 2016. Of these, the most common type of incident reported was pressure ulcer meeting SI criteria (seven incidents).
- In order to address the problems with pressure ulcers a tissue viability nurse consultant at the trust had developed a pressure ulcer notification tool (PUNT), an online system that allowed clinical staff to report and review reliable pressure ulcer data for hospital inpatients. All pressure ulcers above a grade two were reported on an incident form and on PUNT in order to understand the mechanism and how the ulcer could have been prevented. This information was then fed back to ward teams in order to develop further awareness of pressure ulcer management. Data from March 2016 showed pressure ulcer incidences for all hospital admissions at 0.5%, down from a peak of 6% since PUNT was first introduced.
- We saw a copy of the trust incident policy, which clearly outlined the process for reporting and managing incidents. We witnessed the process being followed in relation to an incident about a patient's discharge from Digby Ward. The patient received a full apology and assurance from the ward sister that she would address the particular concerns with the wider team.

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- Incidents were reported through the trust's electronic reporting system. All the staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- Between October 2015 and August 2016, there were 1547 incidents reported in surgical areas at the LCH. Low or no harm incidents accounted for 84% (1294) of the incidents. There were 13.6% (210) moderate incidents, near misses were not recorded. A near miss is an unplanned event, which did not result in injury, illness, or damage, but had the potential to do so.
- There were 38 incidents recorded that resulted in severe harm and 4 that resulted in death.
- On average 141 incidents per month were reported for this core service.
- Incident themes included falls, pressure ulcers and medication errors or omissions.
- Ward and theatre staff were able to give specific examples of learning from incidents and most staff told us they received feedback after reporting an incident. For example following a patient fall the trust had introduced slipless slipper socks.
- All ward managers and managers said they provided feedback through email and newsletters and during ward meetings. We reviewed minutes of monthly ward meetings during our inspection, which included feedback around reported incidents.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff on most wards could describe an incident where duty of candour applied. An example of this was the never event an apology from the surgical team and a letter of apology was sent.
- The trust had a "being open and duty of candour policy". Duty of candour training sessions were being planned for all staff groups. Wards we visited had information boards to raise awareness of duty of candour. The trust had a duty of candour plan with seven objectives and a timeline of completion. This included staff training plans and implementation of a duty of candour website for staff to access.
- Within the individual clinical directorates for the different surgical areas, morbidity and mortality, (M&M) meetings were held monthly. These meetings reviewed

patient deaths and treatment complications, in order to develop improvements to patient safety and aid professional learning. Minutes reviewed between March 2016 and June 2016 demonstrated all unexpected deaths were discussed and trends identified. An action log was created to ensure all actions were followed up and completed in a timely manner. This included any communication with other trusts and services.

- The trust's mortality review assurance group (MoRAG) further reviewed 10% of all mortality and morbidity reviews. We reviewed minutes from the MoRAG meetings for April 2016, May 2016 and June 2016 and found each review detailed any issues flagged by the MoRAG review and where applicable any actions required were taken forward.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and harm free care. Data was collected on a single day each month to indicate performance in key safety areas. It focuses on four avoidable harms: pressure ulcers (PU), falls, and urinary tract infections in patients with a catheter (CAUTI), and blood clots or venous thromboembolism (VTE). VTE is the formation of blood clots in a vein. Each surgical ward collected information on a range of safety measures based on individual patient risk assessments. The results were part of each ward's performance monitoring and included information such as number of inpatient falls, number of hospital acquired pressure ulcers in each of the recognised pressure ulcer grading categories (grade one to four, with one being superficial and four being deep) and number of medication administration errors. We saw this information displayed within all of the wards. Patients and visitors could therefore see how the ward was performing in relation to patient safety.
- Information provided by the trust showed between October 2015 and October 2016 the surgery wards at LCH reported 55 pressure ulcers, 64 falls with harm and seven catheter urinary tract infections.
- Ward managers and matrons attended a monthly meeting to discuss performance and plan actions for their areas in relation to patient safety.
- Where an increase in patient harm had been identified in a ward area, ward managers told us they would raise this with staff via email, newsletters and at ward

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meetings. The ward sister on Clayton Ward showed us how they had reduced falls with harm after auditing the reasons for falls, we also saw information about a reduction in pressure ulcers (PU) and the ward had been 108 days PU free.

- The National Institute for Health and Care Excellence (NICE) Quality Standard (QS) three, statement one states all patients, on admission, should receive an assessment of VTE and bleeding risk. The trust's performance report for March 2016 showed 96% of VTE assessments were completed on admission. Within surgery, completion was 95%. This met the trust's target of 95%.
- The trust provided quality dashboard VTE compliance at LCH which included a review of four specific components. For example the VTE was completed and signed on admission and prophylaxis (preventative medication) was prescribed. Data provided from May 2016- September 2016 confirmed results in line with or above the trust target of 95%. However, this audit data did not include a review of prescriptions after 24 hours of admission.
- The NICE quality statement four states that patients should be reassessed within 24 hours of admission for the risk of VTE and bleeding. In the 17 patient records we looked at, we could not see where a reassessment had taken place. This meant there was a risk of harm to patients.
- Documentation we reviewed during our inspection did not provide evidence that VTE prescriptions were reviewed after 24 hours of admission. This meant some patients may have received anticoagulant (blood thinning) therapy for longer than necessary and could put patients at a higher risk of complications from this therapy.
- Ward and theatre staff told us if VTE assessments had not been completed before surgery anti embolic stockings, (AES), were not applied. These stockings are designed to increase the blood flow in the leg veins by compression. Staff reported that in these instances AES were sent with the patient to theatre to be put on the patient in the anaesthetic room.
- Senior nursing staff in the surgical assessment lounge (SAL) explained that the initial assessment for VTE was nurse led and that this new initiative had increased compliance.
- Lincoln County Hospital (LCH) participated in 'Patient-Led Assessments of the Care Environment' (PLACE) 2016. PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and independent/ private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this hospital demonstrated a compliance level of 93%, which was worse than the England average of 98%. However it was an improvement on the 2015 score of 91%.
- Trust wide there had been 60 cases of clostridium difficile (C. difficile) infections between July 2015 and June 2016 with seven cases occurring at this hospital in the surgical areas. C. difficile is an infective bacterium that causes diarrhoea, and can make patients very ill.
- Meticillin Resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between July 2015 and June 2016, there were no cases of MRSA reported at this hospital.
- Patients were screened pre-operatively for MRSA as soon as possible when admitted as an emergency. This was in line with local policy and national guidance.
- Meticillin Sensitive Staphylococcus Aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between July 2015 and June 2016 there were 35 recorded cases of MSSA at this trust, of which nine occurred at this hospital within the division of surgery.
- The trust had reported no surgical site infections for the period April 2015 to March 2016 at LCH. Surgical site infection surveillance (SSIS) is mandatory for all trusts although not all categories of surgery are required to be included. The trust reported on surgical site infections for hip and knee replacement surgery.
- In order to measure compliance with trust policies, the infection prevention team (IPT) carried out regular audits. The standard precautions audit incorporated source isolation (a strategy used to prevent the spread of contagious infectious diseases), sharps safety, availability and appropriate use of personal protective equipment (PPE) and measurable elements of the MRSA Policy.
- All Infection prevention and control issues were highlighted to the nurse in charge and a written report sent to the ward sister, matron and head of nursing. An action plan was formulated by the ward sister and

Cleanliness, infection control and hygiene

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issues reported at the site meetings. The action plan was reviewed at the next site meeting to ensure all issues had been addressed. We saw minutes of these meetings and actions taken for example in relation to sepsis.

- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Overall compliance between January 2016 and June 2016 for surgical areas was 99%. This was better than the trust's target of 90%.
- All wards in surgery displayed information regarding individual hand hygiene results and displayed information boards for staff and the public about the importance of hand hygiene.
- There was access to hand washing and drying facilities on wards and a good supply of personal protective equipment (PPE), which included gloves and aprons. Nursing staff used these items and disposed of them correctly afterwards. We observed staff wash or cleanse their hands between patient care duties and when going about their activities on wards. We saw that staff followed best practice guidance when giving intravenous fluids and taking blood samples.
- We saw staff were bare below the elbow to allow for effective hand washing.
- We saw patients with infections nursed in side rooms and appropriate signage in place to alert staff and visitors of action they needed to take. Personal protective equipment was provided for staff. Visitors were advised about hand washing and wearing gloves and aprons as required. We witnessed staff on the surgical emergency assessment unit (SEAU) appropriately caring for two patients in side rooms according to hospital policy.
- We observed staff following National Institute of Health and Care Excellence (NICE) clinical guidelines [CG74] 2008 surgical site infections prevention and treatment within theatres. For example, there was hand cleansing gel on entry to anaesthetic rooms. Theatre staff were observed to adhere to best practice principles for 'scrubbing up', (rigorous hand and arm washing), prior to surgery and for the management of surgical equipment in the operating environment.
- The standard of cleanliness of surgical ward areas, pre-assessment rooms, operating theatres and recovery was visibly good. The trust produced a cleaning handbook, which was available on each ward detailing the schedule of cleaning. However, senior nursing staff on Neustadt -Welton ward did tell us that it was often difficult to maintain cleaning schedules on the ward due to its high number of ensuite facilities. The ward had four bays and 12 side rooms with en-suite facilities. In order to maintain cleaning schedules three housekeepers were allocated to the ward however, with staff shortages in housekeeping they were moved to other wards at least twice a week. As the housekeepers were responsible for food preparation and cleaning this caused difficulties in completing the full cleaning schedule.
- We saw that all equipment used by patients was visibly clean and appropriate for use. The trust used 'I am clean' stickers for staff to sign indicating where equipment had been cleaned. We reviewed 20 items of equipment; we saw the use of 'I am clean' stickers on 15 of these items of equipment. Therefore, we were mostly assured equipment had been cleaned before patient use.
- Throughout the hospital, privacy curtains were a mixture of disposable and non-disposable. Nursing and housekeeping staff told us the schedule for changing them was four monthly but that they were changed if visibly soiled or following patient isolation. The disposable curtains had dates on them indicating when they were put up and routine changes were scheduled every four months. In accordance with Health Building Note 00-09: Infection control in the built environment regulations which states; there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known/or suspected infection.
- We saw evidence that the trust infection prevention and control team were in the process of scoping the need for disposable curtains trust wide due to ongoing problems with old reusable curtains not fitting or being damaged.
- The trust policy for clinical waste disposal was written in line with The Safe Management of Healthcare Waste Memorandum (HTM 07-01) issued by the Department of Health. This recommends the segregation of clinical

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waste occurs at the point of production using colour coded waste receptacles and outlines a best practice waste segregation colour coding scheme for producers of waste to follow.

- We observed staff in all surgical areas at the LCH disposing of clinical, domestic and recyclable waste. All wards and theatres had access to domestic and recyclable waste bags. However, blue clinical waste bins on all ward areas for the disposal of medicines contained other items of non-medicine waste. For example syringes and cardboard packaging, this filled the containers more quickly and increased the cost of disposal to the trust.
- Senior nursing staff we spoke with were aware of the trust policy regarding tap flushing for legionella infection prevention. Legionella is a waterborne bacterium, which causes legionnaires disease. Infrequently used taps and showers were flushed on a daily basis and recorded to monitor compliance. Water testing was completed across the hospital and any areas found to be of higher risk were subject to three times a day flushing and recording. We were shown evidence on Shuttleworth Ward as the housekeeper completes the documentation and the wards sister reviews it weekly to ensure compliance.
- Water coolers were available on wards we visited to supply fresh cool drinking water to staff and relatives. We reviewed three coolers all had been water and safety tested in October 2016.

Environment and equipment

- There were single rooms available for use on each ward. Priority for these rooms was given to patients who were particularly unwell or needed to be isolated because of infection.
- Resuscitation equipment, including emergency medicines, was readily available in all surgical areas and theatres. A difficult airway trolley, providing additional equipment for emergency use, was also available in the theatre suite. Records showed staff signed daily checks for emergency equipment, which were completed in line with trust policy. We reviewed the records for previous months and were assured this was a consistent practice. We opened five resuscitation trolleys and found them all to be stocked appropriately with essential equipment.
- Re-stocking of resuscitation trolleys was carried out after use or in the event of out of date stock.
- Technical equipment used for monitoring patients had been safety tested and stickers indicated the next date for further checks. We reviewed 15 pieces of equipment, for example; blood pressure monitors and hoists; all had been appropriately tested and were within their service date. Electrical equipment we saw had been tested annually as per safety test recommendations.
- Clinical areas had limited storage for equipment; however, stock items were kept on each ward for example intravenous fluid pumps. The trust carried out preventative planned maintenance on all equipment stocked on wards. This included items such as, syringe pumps, pressure-relieving mattresses and infusion pumps. Each ward had a set number of specific pieces of equipment.
- Nursing staff, we spoke with on the surgical emergency assessment unit (SEAU) felt there were not enough infusion pumps available on their area. They told us they prioritised which medications or fluids were administered through a pump. Manual adjustment of flow may cause a patient to be over or under infused with fluid or medication if not monitored correctly. We saw one patient being administered fluid without a pump during our visit; their clinical condition would indicate they would require an infusion for this fluid.
- In 2015, we found bariatric (equipment for heavier patients) was not always available. During this inspection there were no patients requiring this type of equipment. However, staff we spoke with told us wheelchairs were available and staff would speak with the manual handling team if they required any further equipment for example specialist beds or hoists.
- Theatre staff reported having sufficient equipment to undertake their roles. For example equipment trays and patient trolleys.
- The difficult airway society launched guidelines for management of unanticipated difficult intubation in 2015. We saw a difficult airway trolley, which contained emergency intubation equipment, was available in theatres. Intubation is the placement of a flexible plastic tube into the windpipe to maintain an open airway. The trolleys contents met guidance and current best practice and we saw daily checks were completed in line with trust policy.

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- Control of Substances Hazardous to Health (COSHH) was in line with guidance from the Control of Substances Hazardous to Health Regulations 2002. We found hazardous cleaning fluids were always stored in locked cupboards away from patient areas.
- Ward managers told us COSHH information was available on the intranet and showed us data sheets were available.

Medicines

- Medicine errors, including those resulting in harm, were reported as part of the incident reporting process. Medication incidents were reported on a monthly basis to the medicine optimisation and safety committee. During July and August 2016 there were 134 and 109 incidents respectively reported at this trust. Of these 90 % were low or no harm. Between July 2015 and June 2016, seven serious incidents had been reported .Three of these related to prescribing and administration of venous thrombo embolism (VTE) medications.
- All medication errors were discussed with heads of nursing and matrons in surgical and theatre areas for action at ward level. Ward managers explained the changes in the risk assessment of VTE medications as a result of these incidents. The chart and assessment had been made easier to use.
- Nine VTE prescriptions were checked all were completed accurately .However; one chart had a dose of a blood thinning medication omitted with no reason identified.
- The top two reasons for raising incidents were omitted medicine and wrong dose prescribed.
- Staff were able to discuss incidents where errors had occurred and described the actions taken to help prevent a similar error. For example, medication charts were checked at staff handovers to ensure missed doses or signatures could be identified immediately. We saw ward managers also completed a three times weekly ward assurance checklist where medication charts were also reviewed for accuracy.
- Nursing staff confirmed they had access to regular pharmacy advice. The pharmacists visited the wards daily Monday to Friday, to check prescription records and raise any queries with doctors. Staff on all surgical ward areas told us they received a visit from a pharmacist in the afternoons. However, this was not always timely to facilitate same day discharges.
- There were local microbiology protocols for the administration of antibiotics. The pharmacist monitored antibiotic prescribing to ensure patients were prescribed antibiotics in accordance with these protocols and a microbiologist was available to advise doctors with antimicrobial selection.
- Medication charts for seven patients were reviewed and found to be complete, up to date, and reviewed on a regular basis by the pharmacist. Patient's weight and any allergies were also recorded. Records showed patients were getting their medicines when they needed them.
- Controlled medicines, (these are medicines controlled under the Misuse of Drugs regulations 2001, these legal controls govern how controlled medicines can be stored, produced, supplied and prescribed), on the wards and in theatres medicines were stored appropriately and drug records were accurately completed. Emergency medicines were available for use and these were in date and replaced by pharmacy when used.
- Disposal arrangements were in place for out of date medicines, or medicines which were no longer required. Medicines were disposed of in blue medicine disposal bins or returned to pharmacy.
- Intravenous fluids were stored in locked cupboards in treatment rooms on wards. This reduced the risk that intravenous fluids could be tampered with or accessed by unauthorised people. However, fluids containing potassium were stored in close proximity to other fluids resulting in a risk of selecting the wrong fluid. This contravenes guidance issued following the 2002 National Patient Safety Agency alert specifically about storage and handling of potassium chloride concentrate and other strong potassium solutions.
- There were arrangements in place for the storage and management of medicines in surgical areas, including theatres and recovery. However, Neustadt-Welton ward had a clinic room, which often became very warm. In order to monitor and maintain safe storage of medications, a room thermometer was in place and we saw temperatures were checked daily. An air conditioning unit was in place to use if temperatures rose above the recommended storage temperature of 25 degrees Celsius.
- Medicines requiring refrigerated storage were stored at the correct temperatures to ensure they were fit for use. On all of the wards we inspected, the temperature

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checks for the medication fridges were undertaken by the ward teams. Fridge temperatures were recorded, including current lowest, highest and actual. Because of this, we could be assured medicines were stored safely. We saw on one ward that the temperature of the fridge had increased to 10 degrees Celsius on two occasions the previous month. We saw it was documented on the chart actions taken (removal of medication) and a repair of the fridge.

Records

- Patient's individual care records were written in a way that kept patient's safe. All members of the multidisciplinary team (MDT) documented in the same notes. This provided consistency when reviewing notes and identifying changes in patient condition or treatment.
- However, patient records were not always well maintained, we found some contained loose pages that had not been filed. This meant that some records were difficult to look through and there was a risk that some records could be misplaced or lost. This was also highlighted in our 2015 report. In addition, records were not always written in date order.
- Throughout the wards, patient identifiable information was stored in open unlockable trolleys. We could therefore not be assured confidential patient information was safe from access by unauthorised persons
- Patient plans were documented daily on blue proformas ensuring that staff could immediately identify the current plan for any patient.
- Doctors on many of the wards had been provided with an ink stamp of their name and general medical council (GMC) number. This ensured correct identification of the doctor that had reviewed the patient.
- Signature legends (a list of names written legibly with an identifying signature), were also available in the nursing admission document. We saw a wide range of staff completing these including nurses' occupational therapists and physiotherapists. However, doctors without a stamp were not completing them. Staff we spoke with on surgical emergency admissions unit (SEAU) felt that this might have been because it was inside a document, which stated 'nursing admission' so doctors did not feel it related to them.
- We reviewed 22 sets of medical and nursing records. All patient nursing risk assessment documentation was

completed appropriately. For example, falls, bed rails, malnutrition scoring and pressure ulcer assessments. However, care plans were not always individualised for each patient. This meant care may not be tailored specifically to each patient's needs for example preferred foods. The nursing assessment document does direct staff completing it to "activate and personalise" a care plan in response to issues identified.

- Pre-operative checklists were completed which included a record of consent. These checklists ensure certain safety elements were completed prior to any surgical procedure. For example patient identification, allergies, correct consent and the time of last food and drink.
- Whiteboards, (for essential patient information), on each ward were usually facing the nurses' station. However, full names were not displayed. This meant that patient confidentiality was maintained.

Safeguarding

- The trust had a safeguarding lead at executive level, in addition to local named leads for children and adult safeguarding. All staff we spoke of were aware of the safeguarding leads and none reported any problems accessing them.
- There were safeguarding link nurses identified on the ward areas whose aim was to update and support staff with regard to safeguarding processes and information.
- All staff we spoke with were clear about what constituted a safeguarding issue and how to escalate a safeguarding concern.
- Information received prior to our inspection showed as of September 2016 that surgery trust wide had training compliance at level one in safeguarding children of 92% and, safeguarding adults 92%. This did not meet the trust target of 95%.
- Female genital mutilation (FGM) is defined as the partial or total removal of the female external genitalia for non-medical reasons. Nursing and medical staff spoken with confirmed that they had received FGM training which was included as part of mandatory training.

Mandatory training

- Mandatory training for all staff groups included; fire safety training, moving and handling, infection prevention, equality and diversity, information governance, health and safety and, basic life support.

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- Clinical staff we spoke with were aware of the trust physiological observations and sepsis policy (July 2016). However, the trust had no formal sepsis training at the time of our inspection.
- Information received prior to our inspection showed, as at September 2016, training compliance in surgical business units trust wide was an average of 89% across all subject areas for both medical and non-medical staff. This was below the trust target of 95%.
- Mandatory training was accessed either through an electronic learning tool or, for some subjects, face to face. Nursing staff told us face to face training was sometimes difficult to attend because it was held on different days and would often only be for a few hours, this meant they would often have to leave the ward to attend. If the wards were busy, they would not always be able to attend.
- However, ward managers we spoke with on all of the wards tried to plan training into the electronic roster to ensure the wards were covered and training was attended in a timely manner.

Assessing and responding to patient risk

- The service ensured risk based pre-operative assessments were carried out in line with guidance on pre-operative assessment for day and inpatient cases.
- Patients admitted for emergency surgery were assessed on admission using the American Society of anaesthetologists classification system (ASA). Patients were assessed with regard to their health on admission against six criteria with one being a healthy patient and six being a patient already clinically dead.
- Theatre staff we spoke with told us consultant anaesthetists and surgeons reviewed all emergency patients. The service ensured that there is access to consultant surgeons through the on call system which allocated a named consultant with overall responsibility for the service.
- Clinical staff followed the nationally recognised five steps to safer surgery checklist. Staff used a document based on the World Health Organisation (WHO) safety procedures to ensure each stage of the patient journey from ward through anaesthetic procedures, operating room and recovery was managed safely.
- The recovery theatre team chose a random sample of 100 patients to review (audit) compliance with the documentation. The audit was submitted to the clinical governance department; the results were developed into a WHO checklists dashboard and reported on a monthly basis to the trust board.
- Information provided by the trust for August 2016 identified an overall compliance of 98.3% against a target of 100%.The trust identified that failure to complete the sign out of theatre section was the commonest omission. In order to address this the trust asked the theatre teams to accompany the patient through into recovery to complete the process. We witnessed this during our inspection.
- We reviewed the use of the WHO safety checklist in ophthalmology theatres, orthopaedic theatres, head and neck, and during an orthodontic procedure. In each theatre, the checklist was followed and completed by all members of staff .In ophthalmology the lens for implantation was checked by two staff before opening and three staff checked the joint in orthopaedics, to ensure patient safety.
- Interventional radiology, breast imaging and ultrasound had adopted the World Health Organization (WHO) surgical checklist. Staff in interventional radiology told us that use of the checklist had been audited for the three months prior to the inspection which showed that 100% of procedures had had a completed checklist.
- Day surgery patients mostly received care in line with the best practice guidance from the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery Guidance 2011.
- The Association of Anaesthetists guidance states it is best practice to have a dedicated telephone helpline for patients during the first 24 hours post day surgery. The day surgery unit had a dedicated contact line for patients in place. Advice leaflets were also given to each patient about complications and problems that may occur during the first 24 hours.
- A National Early Warning Score (NEWS) was used for patients across the hospital to assist staff in the early recognition of a deteriorating patient. NEWS is a guide used by medical services to quickly determine the degree of illness of a patient. Staff recorded routine physiological observations such as blood pressure, temperature, and heart rate to assess whether a patient's condition was deteriorating. We saw NEWS documentation was completed appropriately which meant that patients were being monitored for signs of deterioration and could be treated in a timely way.

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- During our inspection we reviewed 22 patient observation charts across six clinical areas. Nursing staff adhered to trust guidelines for the completion and escalation of NEWS. All charts reviewed had full observations recorded which included blood pressure (BP), heart rate, respiratory rate, SPO2 (an estimate of the amount of oxygen in the blood), temperature and urine output. Pain scores were recorded on all charts reviewed. NEWS had been completed correctly at each time of recording the patient's observations. If patients required fluid balance charts, all of these were up to date and accurately calculated. Patients scoring on their NEWS were required to have further set of observations recorded within a set timescale for example from four hourly to one hourly. Of the 22 charts reviewed, all patients had observations performed in line with the trust 'escalation of NEWS monitoring in adult patients' with the exception of one patient who was not for escalation.
- United Lincoln Hospitals NHS Trust (ULHT) had a sepsis overview action plan 2016-2017, produced in response to a sepsis review in 2015 following being identified as an outlier with more patients dying from sepsis than expected between December 2014-December 2015. An outlier is when results are below the expected range against the England average. This included the launch of a sepsis bundle in April 2016, providing clear guidance on the detection and treatment of suspected sepsis and an e-learning package for all front line staff. Sepsis screening measures included patients who received intravenous antibiotic therapy within one hour of sepsis the trust target was 50% but the trust result showed just 38% compliance between April and August 2016.
- There were plans in place to improve performance throughout the trust. This included the roll out of sepsis boxes in all clinical areas and the introduction of a patient group direction (PGD) for an injectable antibiotic. A PGD is a set of instructions, which detail the conditions under which a prescription medicine can be supplied to patients without a prescription. A business case had also been made to recruit two full-time sepsis nurses, one of which would be based at this hospital. There was also a plan for the roll-out of an electronic learning package. The quality and safety manager and associate medical director told us they were confident there would be an improvement in sepsis management and treatment within six months of our inspection.
- We reviewed the observation charts for two patients who had scored a NEWS of three or above. Both patients were appropriately screened for sepsis in line with the sepsis pathway. Sepsis is a life-threatening condition that happens when the body's response to an infection injures its own tissues and organs. Where specific interventions had been required, we saw where the Sepsis Six Care Pathway had been completed in a timely way. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality (death) of patients with sepsis, it consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis for example administering oxygen and intravenous (IV) antibiotics. Sepsis Six has been associated with decreased mortality.
- Staff took the time to identify and respond to the changing risks of patients. For example, the adult inpatient care risk assessment booklet included a tissue viability assessment and pathway. Patients assessed as at risk in pre-assessment had a pressure-relieving mattress ordered for the day of admission. This ensured that patients with delicate skin at risk of possible pressure damage were identified early and risks could potentially be reduced.
- The admission booklet also contained a falls multifactorial assessment that included for example, patient history, footwear and eyesight assessments. This ensured all factors that could contribute to a patient's risk of falls were reviewed.
- We saw evidence on the surgical emergency assessment unit of staff responding appropriately to the changing risks of a patient. The patient had suddenly become unwell, staff acted promptly to have the patient seen by doctors and advanced nurse practitioners from three different specialities in order to identify the best course of treatment. We were particularly impressed with the timeliness of all interventions and the communication between the teams. Every member of staff worked together seamlessly identifying the patients' needs and providing the appropriate care.
- We also witnessed a patient on Neustadt-Welton Ward suffer a collapse. The team calmly managed the incident and quickly requested the assistance of the high intervention team (HIT) to gather extra help from intensive care outreach team. The outreach team/HIT supported ward staff in the detection and management of critically ill and deteriorating patients.

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- We observed staff serving lunch on Greetwell Ward. Food temperatures were checked before serving. This meant food was served at the correct temperature to reduce risks of food poisoning.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times. Patient acuity and dependency data was collected using a nationally recognised safer nursing care tool. This tool measured the individual dependency of patients and calculated how many nurses were needed to care for them.
- National Institute of Clinical Excellence (NICE) guidance (SG1) recommended assessment but did not override the need and importance of using professional judgement to make decisions appropriate to the circumstances.
- Following a trust wide acuity assessment in October 2015 and April 2016, formal establishment reviews had been undertaken in the Lincoln surgical business unit. The reviews were led by the chief nurse and had full input from the deputy chief nurse, heads of nursing, head of midwifery, matrons and ward managers/charge nurses. The outcome of this was to ensure 1: 8 nurse to patient ratios on all surgical wards.
- Each ward at Lincoln County Hospital (LCH) had a 'safe staffing board' at its entrance displaying planned and actual staffing. During our visit, all the of wards met the trust requirement of 1:8 nurses to patient ratio. Staff we spoke with on Clayton Ward explained that due to the acuity of their patients staffing ratios were generally 1:6 .This was because of the specialist care required by patients with a tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing).
- Information supplied to us by the trust for June 2016 showed 32 whole time equivalent (WTE) vacancies for registered nursing staff and 16 WTE vacancies for healthcare assistants and other support staff (a total of 14.3%). The trust had a rolling programme of recruitment, including recruitment from overseas.
- Staff turnover in surgery at LCH was 5.7 % between April 2015 and March 2016 this is based on 23 whole time equivalents leaving. Staff turnover refers to the number or percentage of workers who have left an organisation and been replaced by new employees.
- All staff reported the use of hospital bank staff rather than agency in order to provide 'cover by staff that knew the hospital'. The reported use of bank/agency nurses in surgical areas at LCH was 16.45% during the period April 2015 to March 2016.
- Ward managers/charge nurses told us this was because of vacancies and sickness rates and the difficulty of recruiting to a rural area. In the last financial year Lincoln County Hospital reported a sickness rate of 4.42% in surgical care; The total number of WTE days lost was 4136.50 this meant that wards were reliant on using bank/agency staff to maintain nurse/patient ratios of 1:9.
- Ward managers within surgery during our inspection explained that they had recently recruited to almost all vacant posts. Recruitment was mainly from newly qualified nurses that had experience within the department and had wanted to stay at the trust. This placed an initial pressure on other staff providing support to newly qualified staff however, all ward managers and nurses we spoke with were keen to support and develop these new nurses as part of their teams.
- Senior nurses in main theatres told us there were 14 WTE vacancies at LCH. Information provided by the trust indicated 10 WTE vacancies however; this did not include obstetric theatres.
- Nurses on all wards described their concern regarding the staffing of beds in the surgery assessment lounge used for overnight surgical escalation. All staff understood the need for a substantive member of staff in the area. However, they voiced concerns that the site matron did not take into account acuity on the base wards before moving staff. Three nurses on one ward had been moved to the day case area over one weekend leaving only one nurse qualified to administer intravenous medications to 17 patients. All of the nurses felt that this reduced morale on the wards as they felt the concerns they raised were dismissed. Following our inspection the trust told us that risk assessment were undertaken to ascertain the safest ward area to complete the substantive skill mix swap for the escalation area. During our inspection we did not have the opportunity to observe this process.

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- Agency and bank staff received a local induction checklist to the ward area, which included the location of emergency equipment, ward orientation and working procedures. The nurse in charge signed this with the temporary staff member to confirm completion.
- The trust was in the process of commencing an agency/bank nurse engagement package. This included the 'block booking' of agency and bank staff to maintain continuity of patient care and skill mix and an incentivised scheme to earn additional training opportunities within the trust.
- Nursing handovers were held each day on the wards to discuss in detail individual patient needs and risks. This highlighted to staff which patients needed most attention and allowed them to gain an oversight of the ward as a whole. A post ward round 'safety huddle' was observed on Greetwell Ward. This updated staff on any changes that may affect patient safety. Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care.
- We witnessed a handover on surgical emergency admissions unit (SEAU). It was well structured and information discussed included patients going to theatre, patients requiring investigations, patients being discharged, pain management, medication and Deprivation of Liberty Safeguards (DoLS) assessments. Deprivation of Liberty Safeguards (DoLS) are a set of checks that aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests.
- The agency/bank nurse induction package also displayed guidelines of how a handover should take place and what should be in it. This was to ensure handovers were consistent and safe at all times.
- In 2015, inspectors were not assured that medical staffing in the oromaxillofacial service (OMFS) was appropriate to provide the service. During this inspection nursing staff we spoke with on Clayton Ward said they would not hesitate to call a consultant OMF surgeon if one was required and it was usual that they would be happy to be called 24 hours a day if necessary.
- The medical director confirmed that recruitment into substantive consultant posts in OMFS was still a concern. The service had one substantive consultant in post and two locum consultants in post for in excess of one year. As a result of this, the trust had reduced the surgical services provided in order to provide a smaller service.
- Between April 2015 and March 2016 Lincoln Hospital reported a turnover rate of 31.77% in surgical care, this was based on 82.00 WTE.
- The sickness rate for Lincoln County Hospital from the last financial year was 0.51% for the surgical wards, the total number of WTE days lost was 312.53
- Surgical doctors, registrars and consultants from all specialities were on call to provide advice and care 24 hours a day. Junior doctors and registrars were available on site during the day, including at weekends. Consultants were on site during the weekdays and were available to attend the hospital out of hours when necessary. We were told on call staff were available when offsite within 30 minutes. There were doctors based on SEAU at all times.
- Handovers took place daily, seven days a week for all general surgical and orthopaedic patients. The on call doctors (foundation year two or trust doctor level) had a 30-minute overlap in their shifts, which allowed for a handover of all admissions and any concerns regarding acutely unwell patients.
- A theatre meeting took place each morning attended by the anaesthetic team, theatre team, consultant and surgeon on call for the day to decide any changes to the lists. Medical handover for anaesthetics took place twice a day for theatres, which allowed for a review of theatre lists and any concerns to be discussed.

Surgical staffing

- The proportion of consultants reported to be working at the trust throughout the surgical wards was 40% lower than the England average of 43%. However, the number of junior doctors at this trust was 21% higher than the England average of 11%.
- Information supplied to us by the trust for June 2016 showed there were 17 WTE medical staff vacancies
- Between April 2015 and March 2016 there was a locum usage of 20.7% throughout surgical services at LCH.

Major incident awareness and training

- A major incident plan version six (approved July 2016) was available for staff to access through the intranet.

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This detailed action to be taken by ward staff in the event of a significant incident within the trust or a major incident. Staff we spoke with did not direct us to this intranet plan.

- Staff were able to tell us where the trust's major incident plan was kept on the ward. We looked at the major incident plan on all wards we visited. It contained a preface from 2004 and the latest change of information in the folder was 2008. We could not be assured that this plan was in line with current local major incident planning and that staff were aware of what responsibilities they may have as part of it.
- Staff were not aware of the trust business continuity plans. Staff were unaware of any guidance in relation to what would happen if the electricity or water supply failed. However, they did all say they would contact the site matron/manager for help and advice. We could not be assured that business continuity in surgery was given priority at this hospital.
- Staff were unaware of any major incident exercises, which had taken place in theatres or wards. The trust provided no information in relation to training as part of emergency planning.

Are surgery services effective?

Good



We rated effective as good because:

- Patients care and treatment was planned and delivered in line with current evidence based guidance.
- Staff were qualified and had the skills they needed to carry out their roles effectively. For example the ongoing development of the advanced nurse practitioner role.
- Staff in the surgical emergency assessment unit for example worked collaboratively to understand and meet the range and complexity of patients' needs.
- Consent to care and treatment was obtained in line with legislation.

However,

- Medical staff in the head and neck clinical directorate were not always compliant with the trust appraisal process.

Evidence-based care and treatment

- Patients care needs were assessed throughout their care pathway. Care and treatment was delivered in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and the Royal College of Nursing guidelines. For example, the use of National Early Warning Scores (NEWS), complied with the recommendations within NICE guidance CG 50 acute illness in adults in hospital: recognising and responding to deterioration.
- Policies were up to date and followed guidance from NICE and other professional associations for example, the Association of Perioperative Practice (AfPP). Local policies, such as infection control policies were written in line with national guidelines. Staff were aware of these policies and knew how to access them on the trust's intranet.
- We saw examples of policies and procedures, which were based on nationally recognised guidance. The inpatient care and risk document, completed for every patient, contained the malnutrition universal screening tool (MUST); this identified adults who were underweight or at risk of malnutrition. A nationally recognised screening tool was used to identify patients at risk of developing pressure ulcers and a falls multifactorial assessment that included for example, patient history, footwear and eyesight assessments.
- The adult inpatient risk assessment booklet also included information on how to recognise a pressure ulcer and a flow chart for completion guidance for each risk assessment. We reviewed 22 sets of medical/nursing notes and all appropriate risk assessments were completed. However, in three documents reassessment of pressure ulcer status had not been completed on transfer of a patient to another ward area. Ward sisters was aware that this was sometimes a problem and was reminding staff to reassess all patients on transfer from other wards to ensure documentation was accurate.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend patients with certain co-morbidities (multiple medical conditions) are reviewed pre operatively by an anaesthetist. Examples include age, heart disease (myocardial infarction and angina), heart failure, ischaemic brain disease (stroke and transient ischaemic attacks).
- The majority of patients with multiple medical conditions or increased complications of anaesthesia were seen in a pre-assessment clinic with access to an anaesthetist. This ensured patients at high risk of

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complications were prepared for the procedure and an appropriate anaesthetic selected prior to surgery. For example, some surgical procedures were carried out under a spinal block eliminating the risk of general anaesthesia. (Spinal block is a form of localised anaesthesia involving the injection of a local anaesthetic into the back). We saw documentation and spoke with two patients who had attended this clinic. Nurses in the clinic told us that they would always speak with an anaesthetist if there were any concerns.

- During admission, comprehensive care pathways were in place for patients undergoing anaesthesia for surgery, including localised and general anaesthesia. Care pathways are multidisciplinary plans of anticipated care and timeframes. This meant there was a standard system in place for each patient admitted.
- An enhanced recovery procedure was in place for patients having hip, knee, or colorectal surgery. Enhanced recovery is an evidence-based approach that helps people recover quickly following major surgery.
- We saw a copy of the enhanced recovery checklist for colorectal patients, which included information for the patient on what they could expect before and after surgery and discharge information. The colorectal nurse specialist saw patients' pre surgery and food supplementation was given.
- The elective orthopaedic patients were prescribed pre surgery analgesia (pain relieving tablets) and were consented for the national joint register as part of the enhanced recovery programme.
- Surgical staff were observed to be following the NICE guidelines for the prevention and treatment of surgical site infections. The surgical site infection surveillance team (SSIS) monitored surgical site infection in the following areas, total knee replacement/revision and total hip replacement/revision.
- Across the surgical division, we saw there were arrangements in place aligned to the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery. Examples included a dedicated surgical assessment unit, a consultant-led service with consultant availability at all times for telephone advice, a dedicated surgical team free of elective commitments to cover emergencies and emergency theatre availability at all times.
- United Lincolnshire Hospitals Trust (ULHT) followed NCEPOD, (National Confidential Enquiry into Patient Outcome and Death) guidelines for patients requiring

emergency operations after 10pm. This meant patients, operated on after 10pm, were recovered in theatre and then returned to a surgical ward. ULHT reported one occurrence of a patient staying in recovery overnight at Lincoln County Hospital (LCH).

Pain relief

- Lincoln County Hospital (LCH) fully complied with all of the standards set out by the Faculty of Pain Medicines Core Standards for Pain Management (2015). For example standardised assessment tools and clear protocols for the management of acute pain by ward staff. The trust had worked towards implementation of all recommendations, particularly those in relation to managing pain in the community. They also regularly liaised with other local pain services through the midlands pain forum.
- A dedicated pain management team covering the hospital could be contacted by bleep/pager. The team included nursing and medical staff. They were available 8am-5pm Monday to Friday, over the weekends this service was covered by anaesthetists. All patients who required major elective surgery were referred to the pain nurse pre-operatively who then visited patients following their operation.
- Following surgery, appropriate pain relief was administered in theatre recovery. Patients undergoing orthopaedic surgery had pre-planned pain relief prescriptions. Pain control was discussed with patients pre-operatively and documented in the multi-disciplinary team notes.
- Three patients on the surgical emergency assessment unit (SEAU) told us nurses responded quickly to requests for pain relief and staff returned to ask if their pain had been relieved. During our inspection, we saw nurses on medication rounds asked each patient about their pain and administering analgesia as prescribed. In all 22 medication records we reviewed pain relief medication had been prescribed and given appropriately.
- In the 22 adult in patient nursing assessment booklets we reviewed, all of them had completed the on admission pain assessment and documented where appropriate the patient's pain score using a 0-3 pain score. In nine of the charts pain was identified as a problem for the patient. This should have initiated the use of a pain care plan for the patient. There was a pain care plan for eight out of the nine patients. This assured

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us that pain was managed effectively for the majority of patients we reviewed. However, the patient without the pain care plan was also receiving regular analgesia as prescribed and there was no evidence of discomfort in the medical/nursing documentation.

Nutrition and hydration

- Fluid balance charts were in place to monitor patients' hydration. We reviewed 17 fluid intake and output charts and found that all 17 were completed accurately. This meant that patients' fluid requirements were monitored accurately.
- All patients had their nutritional status assessed within 24 hours of admission using the malnutrition universal screening tool (MUST). The MUST tool calculates the overall risk of malnutrition. Patients considered a lower risk of malnutrition were scored and a prompt was given for nurses to assess and monitor then repeat the assessment after three days. The booklet then advised the nurse further on what to do in certain circumstances. For example, if the patient has swallowing difficulties refer to the dysphagia (swallowing difficulty) nurse specialist.
- Ward staff told us that although a dietician did not necessarily visit the wards daily they knew how to contact the team if necessary. The assessment and MUST tool offered a guide to assist the nursing staff in deciding if a dietician referral was required. Staff told us that dietitians were easily accessible and responded promptly to referrals from nursing staff.
- We reviewed two food charts on Shuttleworth Ward and one on Greetwell Ward, all were fully completed. It was identified that one patient living with dementia required referral to a dietician this was actioned and reviewed in a timely manner.
- Patients were given information about when they must stop eating and drinking before their operation. Depending on the surgical procedure, patients could drink clear fluids up to two hours before surgery and eat up to four hours before surgery.
- Nursing staff said medications for post-operative nausea and vomiting (PONV) were not routinely prescribed. This meant that patients suffering from nausea and vomiting after an anaesthetic would not receive medication in a timely way, as the medication would not necessarily be prescribed until they already had PONV. However, no patient we spoke with complained that this had been a problem.

Patient outcomes

- Anaesthetic provision followed the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists guidance. The trust had not applied for Anaesthesia Clinical Services Accreditation (ACSA). This is a voluntary scheme for NHS and independent sector organisations offering quality improvement through peer review.
- The trust monitored the outcome of patients who had operations for bowel cancer by participating in the national bowel cancer audit. In 2015 patient's outcomes were compared with patients who had the same operation at other hospitals. Patients at this trust were likely to spend longer in hospital after their operation than in other hospitals. Patients who had an operation for bowel cancer at this trust were just as likely to survive as they would if they had the same operation in the majority of hospitals in the country. Survival rates were compared at three months and at two years after their operations.
- Lincoln County Hospital (LCH) had mixed performance in the national emergency laparotomy audit (2015). The audit rates performance on a red-amber-green scale, where green is best. Good performance (green) was shown for two out of the eleven indicators over 80%: final case ascertainment The trust scored amber for seven measures 50-79%. The trust scored red against two measures below 49%.
- Lincoln County Hospital participated in the 2015 national emergency laparotomy audit (NELA). (A laparotomy is an operation performed on the abdomen) The audit compared the care and treatment of 136 patients at Lincoln County Hospital to patients in 185 other hospitals. The audit looked at the care before, during and after operations. Nine patient outcome measures were considered. These included whether scan investigation reports were available before an operation, the timeliness of the operation being started and the level of experience of the medical staff performing the operation and anaesthetic. The trust performed well against these three outcomes and a further three outcomes with over 80% of the 136 patient's receiving the required standard of care. One area where the hospital did not meet the required standard was for patients who were over 70 years of age, as no patients over the age of 70 years been reviewed by

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a doctor specialising in the care of elderly people. There were only two of the 186 hospitals who took part in the audit who met this patient outcome to the required standard.

- The NICE clinical guideline on hip fracture management (NICE clinical guideline 124) recommends surgery is performed on the day of or day after admission. The proportion of patients having surgery on the day of, or day after admission was 85.07%, which meets the national standard of 85%. The 2014 figure was 81.71%, which means that the trust has improved. The guideline states this will have a positive impact on outcomes for patients. In the 2015, Hip Fracture Audit the risk-adjusted 30-day mortality rate was 6.05%, which falls within expectations. The 2014 figure was 9.9%, which means that the trust had improved.
- The perioperative medical assessment rate was 92.4%, which does not meet the national standard of 100%. The 2014 figure was 78%, which means that the trust has improved.
- The proportion of patients not developing pressure ulcers was 95.08%, which falls in the middle 50% of trusts. The 2014 figure was not reported.
- The length of hospital stay was 19.1 days, which falls in the middle 50% of trusts. The 2014 figure was 18.1 days.
- Results from the patient reported outcome measures (PROMs) April 2015 to March 2016 for groin hernia, hip replacement, knee replacement and varicose veins were worse than the England average. PROMs is data collected to give a national-level overview of patient improvement after specific operations.
- The surgical business units provided us with information relating to 29 current local surgical audits. These included audits of consent, length of patient stay and complaints. There were also audits identified to ensure the trust were following best practice in relation to NICE clinical guidelines. For example, an audit investigating outcomes after a certain type of bowel operation (NICE CG131) and an audit of orthopaedic patients suffering kidney problems (NICE CG169).
- The department of anaesthetics at LCH had eight current audits. For example, an audit of treatment for blood clots in the leg veins after a fractured hip (NICE CG92) and an audit monitoring hypothermia prevention in surgery (NICE CG56).
- As these audits were on going, results were not available at the time of our inspection.

- In 2015, the OMFS had completed several local audits however; evidence was not available to assure inspectors that action plans and learning had been shared. During this inspection, the audit lead consultant for OMFS provided further evidence of current local audit. However, we were not assured action plans and learning had been shared.
- On average elective and non-elective patients spent less time in surgery services when compared to the national average. Elective hospital admissions occur when a doctor requests a bed be reserved for a patient on a specific day. The average length of stay for elective patients at this hospital from March 2015 to February 2016 was 2.9 days, compared to 3.3 days for England. For non-elective patients (emergency), the average length of stay was 4.8 days, compared to 5.1 for the England average.
- Between February 2015 and January 2016, patients at Lincoln County Hospital had a lower than expected risk for 30 day non-elective re-admissions. However, there was a higher than expected risk for elective re-admissions for urology and ear, nose and throat (ENT).
- The risk-adjusted 90-day unplanned readmission rate was 29.4%, which makes this hospital a negative outlier. The 2014 figure was 22.2%. The trust was an outlier nationally for the rate of readmissions within 90 days of discharge.

Competent staff

- The trust had systems in place to ensure that the registration status of qualified doctors and nurses' had been renewed on an annual basis. There was a nominated responsible officer for medical revalidation. Nurses told us there were learning events to help with revalidation. The sister on Clayton Ward had developed a folder for each member of qualified staff to assist in reflection and collecting evidence.
- New nursing staff told us they attended a corporate induction and local induction when they commenced employment at the trust. The trust target for attendance at the corporate induction was 95%. Ninety-two per cent of relevant staff. New staff nurses were also given four weeks supernummary status to assist them in settling in to the new trust and familiarising themselves with policies and procedures.
- An induction folder was used on the wards for bank and agency staff. Areas covered on the induction included

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working procedures, ward orientation and medicine administration. The log on two wards we looked at was completed sufficiently to indicate bank and agency staff had been orientated to the ward or clinical area.

- All wards within the surgical business units had a senior nurse with some protected time dedicated to clinical education. We saw documentation on Clayton Ward, which identified the specialist training the nursing team, had undertaken. For example, an on-line tracheostomy training package provided by the National Tracheostomy Safety Project which was developed in conjunction with the Department of Health e-learning for health care project.
- Within the surgical division at Lincoln county Hospital (LCH), as of July 2016, completed staff appraisals were reported to be an average of 68%. However, this ranged from 58% in the head and neck directorate and 100 % in the theatres and critical care directorate.
- All the staff we spoke with described their appraisal as a positive experience, which enabled them to identify their learning needs for the following year. For example, mentor training and assistant practitioner training.
- Staff told us whenever possible they were allocated time to attend training sessions or complete on line training and we saw this in practice. During our inspection, a nurse returning from a period of sickness was undertaking mandatory training updates as part of a return to work programme.
- Advanced nurse practitioners (ANPs) were in post in the surgical emergency assessment unit and the orthopaedic wards. Additional nurse training and education had enabled ANPs to carry out patient consultations and physical examinations, develop a differential diagnosis and prescribe where appropriate. We spoke with three ANPs they were all very supportive of each other and aware of the development of the role in order to support both the medical and nursing teams. The senior nurses on surgical emergency assessment unit (SEAU) explained the benefit of having an ANP available, always having someone with clinical expertise around providing continuity for the patients and the medical staff.
- Four out of five junior doctors in surgery told us they attended teaching sessions and participated in clinical audits. We observed good interactive learning taking place during a patient ward round between the consultant and a junior doctor and an ANP.

- Junior doctors told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- All of the patients who spoke with us reported a high level of confidence in medical and nursing staff with regard to their knowledge and their skills.
- Housekeeping staff and nursing staff handling food told us they had received food hygiene awareness training. The Food Safety and Hygiene (England) Regulations 2013 require that all 'food handlers' are trained and/or supervised and instructed in food hygiene. This meant staff were adhering to regulations.

Multidisciplinary working

- There was good multidisciplinary team (MDT) working across surgical areas. We saw particular evidence of this in the surgical emergency assessment unit (SEAU). For example in order to make an initial diagnosis and stabilise a patient, advice and involvement was required from the physio, a surgical and cardiac nurse practitioner, a junior doctor and a staff nurse. We witnessed them working together in order to provide the best possible outcome for the patient.
- The MDT discussed each patient's condition and progress on a daily basis. However, on most wards staff described the meetings as 'ad hoc'. The sister on Neustadt - Welton Ward was in the process of planning a more formalised meeting in order for the majority of the team to discuss on going patient plans together, rather than the nurses doing individual handovers to other nurses, physio and occupational therapists and doctors. A single meeting would reduce the risk of missing something important about an individual patients care.
- There were weekly multidisciplinary team (MDT) meetings with representation from radiologists, surgical team, oncologists and nurse specialists. Newly diagnosed patients, post-operative patients and onward referral of patients were discussed to ensure continuity and consistency of care.
- White boards were in use on all surgery wards to indicate which patient required specialist input and were updated twice daily following ward rounds.
- Doctors (foundation year two) confirmed they were on call once or twice a month and were well supported by the registrar and consultant team.

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- Two ward rounds were seen being completed in the morning and late afternoon with the medical, nursing staff. This ensured that the patient's needs were met as the patient's care was reviewed.
- The service ensured that access to consultants were available when needed through the roster and on call rota.
- The service met the objectives introduced following the Francis report with the release from the Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients (June 2014) which was implemented by each patient having care under a named clinician and that a named nurse is identified for each patient to improve quality of care. Those names were seen on above the patient's bed and in the patient's care plan.
- Patients were admitted under the care of a consultant who has overall responsibility for each individual's care.
- The physiotherapists and occupational therapists supported patients after surgery and for assessments prior to discharge home.
- Physiotherapy staff we spoke with felt they had continuity of patient care and MDT working as they usually covered the same wards. However, we were told occupational therapy (OT) staff worked on an individual patient basis. Staff on Neustadt - Welton and Shuttleworth Ward told us this often meant an OT would visit the ward and may not be able to answer a specific question about a patient as they were managed by a different team. Staff told us this led to frustration in discharge planning particularly.
- OT staff told us there was effective communication and partnership working between the surgical/orthopaedic teams. However, they felt a more structured approach for identifying patients who required visits or to discuss any changes to the care would be of benefit.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients moved between teams, services or hospital sites, Surgery services were based at four hospital sites of the trust. MDT working within specialist services for example, the pain team and the tissue viability nurse specialists involved linking between the sites. All staff we spoke with felt that the services were available in a timely way despite not necessarily being present at the Lincoln County Hospital site.
- In 2015, significant tensions were found within OMFS with staff working together. During this inspection, we

spoke with staff on Clayton Ward, in theatres, in the OMFS outpatient clinic. All staff reported good working relationships between the team and told us they worked well together.

Seven-day services

- Operating theatres were available seven days a week. An on call rota was in place for surgical and anaesthetic teams. These staff could attend within 30 minutes if needed in the out of hour's period between 1am and 8am.
- Surgical consultants worked an emergency on call rota, seven days per week. A consultant was on call every day Monday 8am to Sunday 5pm. This maintained continuity for patients within the clinical directorates and on the ward. Ensuring patients were reviewed over weekends and bank holidays. This was in line with priority clinical standard six, consultant access.
- We reviewed 22 sets of patient medical notes and all of them showed evidence of a clinical review from a consultant within 12 hours. This was in line with priority clinical standard two, review within 12 hours.
- Seven-day access to an ortho geriatrician, (a doctor that looks after elderly orthopaedic patients), is a key priority in NICE guidance CG124 (hip fracture management). Senior staff told us that covering weekends with an orthogeriatrician was extremely difficult, due to national shortages, but that it would benefit patients if it were available to reduce admissions at the weekend and to improve continuity of care across the service.
- The medical doctors we spoke with told us there was good access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making. This was in line with priority clinical standard five, access to diagnostics.
- However, two patients on SEAU told us they had waited 48 hours for a CT scan to assist diagnosis of appendicitis. It was unclear in the patient notes if this was late requesting of the scan or delay in access to the scan.
- Physiotherapy services were provided seven days a week and an on-call system was in operation if they were required out-of-hours.
- Ward based pharmacists visited the wards Monday to Friday to review medication charts and a pharmacy on-call system was in operation weekends and out of hours

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Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- Comprehensive risk assessments were completed in the inpatient care and risk document. This meant all the information to deliver effective care and treatment was readily available to staff.
- Policies and procedures were accessible on the trust intranet. Staff told us they knew how to access policies and we observed a member of staff searching for a policy.
- We saw a range of up to date policies and procedures on the hospital intranet including duty of candour and the uniform policy.
- Information and guidance regarding specific procedures or conditions was available through the trust's intranet. For example diabetes management pre and post operatively.
- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- We saw in theatres an online, real-time communication system was used. This allowed staff to track patient journeys through theatres and contributed to the management of theatre schedules.
- Some elective surgery patients attended the preoperative assessment clinic where a number of investigations could take place.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- GPs had direct access to the medical staff and could speak to a surgical consultant or other senior doctor for advice on the phone.
- Discharge summaries were sent to the patient's GP on discharge to ensure continuity of care within the community. Summaries were sent on the day of discharge electronically. The discharge letter detailed the reason for admission, any investigation results and treatment undertaken.
- Nursing and medical staff demonstrated to us an understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and had access to the trust policy and procedures for consent.
- Nursing in the surgical assessment lounge (SAL) told us that unless a patient had been consented they were not sent to theatre.
- The sister in the pre assessment lounge told us that 20 % of consents were taken at pre assessment or outpatient department. However, the vast majority 80% were taken on the day of surgery. NHS guidance suggests consent should ideally be secured well in advance, so patients have time to obtain information about the procedure and ask questions. We witnessed same day consent in the head and neck department, ophthalmology and the SAL. This reduces the time patients have to make an informed choice about any non-urgent operation.
- Three patients we spoke with confirmed they had been given sufficient information to help them to decide to proceed with investigations and surgical procedures. They reported they had signed a consent form prior to surgery and verbally consented to blood tests and scans. However, all of these patients were consented on the day of surgery giving no time for further consideration of the procedure.
- Where patients had capacity to consent, consent was sought in accordance with legal requirements and we saw staff recorded discussions with patients about risks, benefits and options about their care and treatment. We observed staff asking for consent both verbally and in writing. On checking a further five patient records (patients with capacity to consent), we saw copies of signed consent forms, which had been completed appropriately.
- Consent form four (a form used for the consenting of patients who lack capacity) was consistently completed in three out of four patient records (patients without capacity to consent). The Mental Capacity Assessment (MCA) had been completed. This meant the patients had mostly been consented correctly.
- Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) training and updates were included as part of safeguarding training. However, most of the staff (except on Shuttleworth Ward) we spoke with had limited knowledge concerning MCA assessments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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- We discussed this with the adult safeguarding lead for the trust. We were told about the pilot of new MCA and DoLs documentation, which was being completed on Shuttleworth Ward.
- The staff on Shuttleworth Ward had received training prior to the pilot in the use of the new documentation. We reviewed five sets of notes containing the new pilot documentation. All five sets of notes had completed MCA assessments and DoLs safeguards or best interest decisions in place where appropriate. Nursing staff said they felt confident using the documentation as it was straightforward and easy to use.
- The safe guarding leads planned to audit the pilot wards and roll out the documentation to other areas.

Are surgery services caring?

Good



We rated caring as good because:

- Feedback from patients who use the service and those who are close to them was mostly positive about the way staff treated people.
- Patients were treated with dignity and respect during interactions with staff.
- Staff responded compassionately when patients needed their help to meet their basic personal needs. For example sitting with a patient living with dementia in case they needed help.

Compassionate care

- Following our inspection, we reviewed information from nine comment cards completed by patients and relatives before our inspection. Responses without exception were 100% positive about the care and understanding received from surgical staff at LCH. Comments were received about the surgical emergency assessment unit (SEAU), Greetwell, Digby, Shuttleworth and Neustadt - Welton wards.
- The Friends and Family Test (FFT) is a single question survey, which asks patients whether they would recommend the NHS service, they have received to friends and family who need similar treatment or care. The overall FFT response rate for surgery was 23% for the period October 2015 to September 2016 with response rates varying between 26% and 32% across

the surgical wards. The England average response rate for the same period was 27%. Each month 73-100% of respondents would recommend the surgical wards and departments at Lincoln County Hospital.

- Ward managers were aware of the low response rates and were giving out more cards unfortunately they were not always completed and they felt that many of their patients were not able to take part in a telephone or text response.
- Eight patients on the surgical assessment unit told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff. They also commented that they had been given enough information about their treatment plan.
- During our inspection, we observed staff were kind, had a caring, compassionate attitude, and had positive relationships with patients using the service and those close to them. Staff spent time talking to patients. During lunchtime, we observed patients being provided with support. We observed staff were kind and respectful when supporting patients to eat and drink taking time to enable patients to eat their meals.
- During a lunchtime observation on Shuttleworth Ward, we observed the kind and supportive interaction of a nurse assisting a patient living with dementia. The nurse took time to sit with the patient in order to help her if necessary.
- Patients on SEAU and Clayton Ward told us, “nurses always answer the buzzer quickly”, “I can’t fault them lovely people”, and “excellent care”. One patient on SEAU told us how they had initially struggled with pain but that the staff had been great and “sorted it”.
- We observed staff on Greetwell, Shuttleworth and SEAU maintain patients’ privacy and dignity by using the curtains prior to any procedures and discussions. They asked patients how they preferred to be addressed and explained procedures.
- We observed physiotherapy staff assisting with patient therapy sessions encouraging mobilisation and self-care activities
- A patient in the pre admission unit told us they always choose Lincoln County Hospital for any surgery as the care was “excellent”. We were also told she had always had a good experience bringing their family members in for care and treatment.
- Medical, nursing staff and patients told us about the lack of privacy in the ophthalmology admissions lounge. It was a large open reception area with no private space

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for discussing anything privately or taking patient consent. Senior nurses had considered other options and were making use of a screen between the desk and the patients however, there were no available rooms in the department for the patients. However, patients were not expected to be changed for theatre in this area.

Understanding and involvement of patients and those close to them

- A patient on Digby Ward told us the staff were “fantastic” and that she felt involved throughout with her care and had special praise for the colorectal nurse specialist. However, she did raise a concern about how “sometimes the night staff were a bit rough and did not seem to be fully aware of how to care for my condition”. The trust were aware of concerns of this nature and were in the process of providing extra training for staff in stoma care. A stoma is an artificial opening made from the bowel onto the tummy for certain bowel conditions.
- The trust had good results for the Care Quality Commission (CQC) inpatient survey 2015 which looked at patient experiences across different hospital departments. This survey looked at the experiences of 83,116 people who received care at an NHS hospital in July 2015. Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at this trust.
- Responses were received from 607 surgical patients at United Lincolnshire NHS Trust. In all 11 questions, they were rated about the same as other trusts. There were two areas the trust were considered worse than other trusts, these were, patients' views – patients felt they were not asked to give their views of the quality of the care provided and information – patients felt they were not given enough information about their condition or treatment.
- Patients told us they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them, doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- We spoke with six relatives, they all told us they had been kept informed of the patients' progress and staff were approachable if they needed to ask any questions. Staff on the wards were aware of patient confidentiality and told us they always checked with the patient if they were unsure of who was making the request for information. All members of the multidisciplinary team explained care and treatment in a way that could be understood. We observed a member of staff speaking with a relative to explain about the patient's care. We observed ward receptionists helping relatives with information requests and taking phone messages to patients from relatives.
- We observed good interactions between staff and patients in the surgical admissions lounge, and the recovery suite of the main theatres. Staff spoke in a quiet calm manner to patients explaining what was happening to them and what was going to happen next.
- Information about surgery was shared with patients, and patients were able to ask questions. Patients and relatives said they were kept informed and felt involved in the treatment received.
- Results from a United Lincolnshire Hospitals NHS Trust carer's survey 2015/2016 identified 107 responses for Lincoln County Hospital. Carers of patients on surgical wards provided 76 of those responses. Ninety-one percent of those surveyed said from a carers perspective they would recommend Lincoln County Hospital. As part of the carers survey a word cloud was developed, the four most prominent words were safe, happy, supported, confident. A word cloud is an image composed of words used in a particular subject in which the size of each word indicates its frequency or importance.
- One carer told us they were treated very well and were fully involved in their relatives care. They were supported to assist with personal care, as this was what the patient preferred.

Emotional support

- We observed staff caring for a distressed relative in the SEAU, offering them support and re-assurance as the patient was upset having been admitted to hospital as an emergency
- There was a trust wide chaplaincy service; we saw this advertised on notice boards within the wards. The chaplaincy team provided an on call service, which was also available out of hours. They provided support and assistance to patients to contact local spiritual or religious priest or ministers. We saw a priest visiting one ward at the request of a patient's family.

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- Patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general.
- Patients and staff had access to clinical nurse specialists across the surgical areas. For example, we saw that there were specialist nurses for colorectal, stoma, breast care and the acute pain team. Clinical nurse specialists supported patients to manage their own health, care and wellbeing and to maximise their independence. We saw the colorectal nurse specialist advising a patient who had a newly formed stoma.
- Patients informed us staff tried their best to make the hospital environment as normal as possible and we observed a number of patients had personal belongings with them such as photographs and items from home if they helped a patient living with dementia. We saw one patient with the soft toy they have at home for comfort on Shuttleworth Ward and a patient living with learning disabilities had various personal belongings that help to calm difficult or unfamiliar situations on SEAU.

Are surgery services responsive?

Good



We rated responsive as good because:

- Evidence collected showed that there were no mixed sex breaches in the surgical division, that the average length of stay was better than the national average and that the number of cancelled operations remained low.
- Patient's needs were met through the way services were organised and delivered. We saw arrangements in place for emergency patients to be reviewed in a triage area on the surgical emergency assessment unit (SEAU).
- Care and treatment was coordinated with other services and providers. For example patients requiring extensive cancer head and neck surgery.
- The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital.
- It was easy for patients to complain or raise a concern. Posters and leaflets were available in the wards and clinical areas these allowed members of the public to identify how they could raise a concern or make a formal complaint.
- There was a proactive approach to understanding and meeting the needs of individual patients and their families and services were planned and delivered to meet the needs of local people.
- Patients had access to a wide range of resources and materials, both online and in paper formats, which were individualised and tailored to their needs. One good example of this was with enhanced recovery programmes.

However,

- The majority of surgical specialties did not meet the 92% target of patients being seen within the 18-week referral to treatment target. The exception to this was ear, nose and throat services where 75% of patients were seen within 18 weeks

Service planning and delivery to meet the needs of local people

- The service understood the different needs of the patients it served and acted on these to plan, design and deliver services. For example, services included a surgical emergency admission unit triage area. Patients referred from their GP could be reviewed and treated here sometimes without need for admission to hospital. The service were currently developing this service further with plans to have an advanced nurse practitioner (ANP) available at all times to assist in the reduction of unnecessary patient admissions.
- The trust engaged with internal and external stakeholders including patients, governors, members, partners and staff to plan services. For example, the trust engaged patients and members of the community to join locality forums to help shape the future of the services provided.
- Local clinical commissioning groups and the national commissioning board commissioned services within the trust. Some specialist services were provided regionally and nationally.
- In planning services, the surgical business unit appointed a number of specialist nurses and clinical educators across the site to support ward provision and to meet the needs of patients requiring specialist care. For example, colorectal nurse specialists ran a patient experience event during April 2016 in order to address any negative concerns patients had and celebrate any positive findings.

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- Patients being seen in outpatients or the emergency department needing specialist facial cancer surgery requiring extensive reconstruction were referred to a nearby NHS trust for their surgical procedure. A joint cancer MDT meeting was held at the receiving trust and involved an oncology and head and neck surgeon from Lincoln County Hospital and the oncology-head and neck surgeons from the nearby trust. This meeting ensured patients, initially seen in Lincoln, were surgically managed in the nearby trust and then safely transferred back to Lincoln for further out patient and postoperative follow up.

Access and flow

- Three site management meetings took place each day (8am, 12.30pm, and 3.30pm) to discuss patient flow into and out of the hospital. Representatives from senior hospital management such as matrons attended these meetings. Any available beds as well as patients who needed admission, awaiting discharge or on outlying wards were identified. From this information, the site management team decided which patients should be admitted to each ward and supported the discharge of patients to make more beds available.
- The trust had procedures in place for surgical outliers. Outliers are patients cared for in an area outside of their speciality (for example, surgical patients on a medical ward). During our inspection, there were no surgical outliers in medical wards. Staff on surgical wards told us during the winter they were often full with medical outliers. During our inspection, there were 14 medical outliers. Staff and patients told us about delays in discharges of medical patients due to the medical reviews not taking place until the afternoon. The trust provided an updated action plan for medical patients outlying on surgical wards whilst it identified only patients awaiting packages of care or in the recovery phase of illness should be outlied it did not address the timeliness of ward round reviews for discharge planning.
- The surgical emergency admissions unit (SEAU) had a computer system linked to the emergency department (ED) so that they could monitor at all times how many patients were waiting in the ED for a surgical bed. We saw staff utilise the system. On the SEAU the nurse in charge telephoned the ED to arrange prompt transfer as soon as a bed was available. However, unfortunately there were delays in transferring patients to other surgical wards from the SEAU. This meant that SEAU had patients with them for two or three days on occasion.
- In June 2015, the admitted and non-admitted operational standards were abolished, and the incomplete pathway standard became the sole measure of patients' legal right to start treatment within 18 weeks of referral to consultant-led care.
- The trust's referral to treatment time (RTT) for admitted pathways for surgical services had been better than the England overall performance since August 2015. Since June 2016, the RTT had not been met. The latest figures for September 2016 showed 60% of this group of patients were treated within 18 weeks. The trust's performance over this time had been quite static and followed national trends.
- For the reporting period November 2015 – September 2016 the RTT was met in just one out of six areas. General surgery, ear nose and throat (ENT), trauma and orthopaedics and urology were not meeting the standard with figures ranging from 57% - 84%.
- Orthopaedics and general surgery experienced difficulties linked to high rates of cancelled operations, with shortages in theatre staffing contributing significantly to this issue. Senior staff we spoke with explained recent successful recruitment within Orthopaedics has increased capacity in this speciality. Agreement had been reached to sub-contract a group of orthopaedic patients to two private providers. Longer-term plans around the use of County Hospital Louth continued to be developed.
- A business case had recently been approved which would increase theatre capacity in general surgery however; there were ongoing risks to this scheme due to staffing vacancies. The business units were exploring the possibility of sub-contracting less complex operations to smaller private hospitals. This would help to reduce waiting lists for certain surgical procedures.
- Between July 2015 and June 2016 cancelled operations as a percentage of elective admissions performance was worse at this trust (1.8%-2%) than the England average (0.8%-1%) Senior doctors and nurses told us this was due to lack of community rehabilitation beds to discharge patients too.
- Eleven theatres were available at this hospital providing emergency and elective surgery. Theatre utilisation (use) was reported to be low for March 2016 to May

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2016. Lincoln County Hospital theatre utilisation averaged 45% during March / April / May 2016. The lowest overall utilisation was 34.5% in March 2016. The highest overall utilisation was 53.9% in March 2016.

- The surgical business units were responsible for scheduling the operations. A team leader worked across the theatres every day to recognise and trouble shoot problems such as capacity, overruns and staffing issues.
- Senior staff told us they made decisions about whether to cancel operations the day before the operation wherever possible. Surgical operations were graded one to three; those graded three were of lower priority and more likely to be cancelled. Patients with cancer were graded one and complex operations requiring surgeons from two specialities were graded two.
- Information from NHS England showed the total number of elective cancelled operations on the day of surgery at the trust between July 2016 and September 2016 was 358. All but 30 of these were rescheduled within 28 days.
- Between July 2015 and June 2016 cancelled operations as a percentage of elective admissions performance was worse at this trust (1.8%-2%) than the England average (0.8%-1%). Senior doctors and nurses told us this was due to lack of community rehabilitation beds to discharge patients to.
- The trust had an escalation policy and procedure to deal with bed availability at busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue. Bed capacity meetings were held three times daily to monitor bed availability in the hospital; they included reviews of planned discharges to assess future bed availability.
- During times of high patient demand, elective patients were reviewed in order of priority to prevent urgent and cancer patients being cancelled.
- Bed occupancy at this hospital was reported at 88.9% for April 2016 to June 2016 against an England average of 90.1%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients.
- Wards and departments included single-gender accommodation, which promoted privacy and dignity. The trust performance reports from April 2016 showed there were no reported times when male and female patients had been treated in a mixed area at this hospital between March 2015 and April 2016. For example, we saw that male and female patients were able to have separate areas in the theatre waiting area.
- The productive operating theatre programme 2014 recommended the lock down of theatre lists to ensure no alterations could be made which may reduce patient flow through theatres. Staff in theatres told us that operating lists were locked down 24 hours prior to surgery; this reduced last minute changes of lists.
- Patients were admitted as emergencies through the surgical emergency admissions unit, through their GP, or directly through the emergency department (ED). Patients sent to the surgical admissions unit would be seen in the triage area by a specialist nurse practitioner or a specialist registrar in order to re direct patients appropriately and reduce admissions. Staff told us that, of the patients admitted through the surgical triage approximately 30% would be discharged with the remaining patients admitted to the surgical assessment unit or another surgical area if necessary. The trust was in the process of formalising the triage area in order to ensure it was staffed by an ANP at all times. During our inspection, staff told us that if the staffing for the ward was reduced due to helping other areas sometimes they could not always have a member of staff in triage. This meant patients may be left unattended whilst waiting for a review.
- Patients undergoing elective orthopaedic surgery were admitted through the surgical assessment lounge (SAL) with the exception of those patients undergoing hip and knee surgery who were admitted directly to Neustadt/ Welton Ward. The SAL provided a facility for patients to be admitted on the day of their surgery, assessed by nursing staff and to meet their anaesthetist and surgeon. The operating theatres were adjacent to SAL. This meant patients were fully prepared prior to surgery.
- Staff showed us the criteria they followed for patients being admitted through SAL. For example, patients with mobility problems that affected their independence, patients with known infections or patients being admitted from nursing homes would not be suitable. The majority of patients seen through the SAL were discharged home the same day. If an overnight stay was required, they were admitted to Neustadt-Welton Ward.
- Patients were advised to contact the SAL or their own GP if they had any concerns following discharge.

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Meeting people's individual needs

- The trust provided an interpretation and translation service available 24 hours a day, seven days a week through a contracted supplier. This service included face-to-face interpreting, telephone interpreting and written translation. Information could be translated into different languages on request. Staff we spoke with were aware of this service and the policy.
- During our inspection, we noted very limited signage in different languages to enable non-English speaking patients and visitors to find their way around the hospital site.
- The trust offered pastoral, spiritual and religious support to patients, relatives and staff. A 24/7 on-call service was provided and where possible a representative of the patient's own faith attended.
- The hospital had a chapel and prayer room. Patients were aware of the prayer rooms available to them.
- All patients were asked about their religious and spiritual preferences on admission and we saw evidence of completed nursing care documents to support this.
- In addition to the nursing documentation, the 'All about me' booklet was included. This document was especially useful in caring for patients living with dementia.
- The patient record identified diabetic patients. The trust had a team of diabetic nurse specialists who received daily reports of diabetic patients admitted to the hospital.
- An inpatient nursing assessment document was completed for all admissions. This included a section on nutrition and hydration. This was mostly completed in all of the 17 assessment documents we reviewed and stated dietary requirements for example 'diabetic' or 'vegetarian', whether any special utensils were required and whether the patient had any difficulties swallowing. However, patient food preferences were not always documented in the 'identify actions' section.
- There were protected meal times in place on surgical wards, which ensured staff had dedicated time to help patients. All ward clinical and administrative staff assisted with giving out meals to ensure that staff able to assist patients were available whilst the food was still warm.
- Patients requiring assistance with eating and drinking were identified using magnetic pictures on the white boards behind their bed. This ensured they were assisted accordingly.
- We saw patients being asked if they required any help with their meals. For example cutting food up or changing position in bed if unable to sit out to eat.
- Nine out of ten patients we specifically asked about food told us they were satisfied with the food and two said that it was "good compared to some hospitals".
- Food was available on the wards throughout the 24-hour period. A range of diet choices was available including vegetarian, gluten free, kosher and halal. We saw housekeeping and nursing staff assisting patients with menu choices. We were told snack boxes were not available for patients who missed a meal. However, nursing and housekeeping staff did have access to soup, baked beans and bread to prepare for patients if required. One staff nurse had suggested that more snack foods be available particularly for patients living with dementia however, when this had been available previously foods quickly became out of date. Staff told us that was why it had been stopped.
- The hospital did not have an electronic system to identify patients who had a learning disability. Two learning disability specialist nurses employed by a neighbouring mental health trust provided liaison support for Lincoln County hospital (LCH). One of the nurses covered LCH and Louth. There was an open referral system and the nurse carried a mobile telephone so they could be alerted of the patient's admission. Information provided by the trust indicated there was a learning disability care plan, which was instigated by the learning disability nurse specialist on referral. However we did not see this on inspection.
- On receipt of notification of an admission, the learning disability specialist nurse contacted the ward to discuss the patient's individual requirements. Staff on all wards were aware of the learning disability liaison team and contacted them if they had any questions or concerns. We observed an episode of care in relation to this service during our inspection on the surgical emergency assessment unit (SEAU). A patient's needs were assessed and adjustments made to enable the patient to have items used at home to relax and calm him. All of the staff caring for the patient were fully informed of specific things that could worry or upset him and how to deal with different events.

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- All patients with a learning disability were initially assessed using standardised nursing and medical documentation. Some patients had their own hospital profiles, (information booklets about their daily lives and their likes and dislikes), and were asked to bring them into hospital with them.
 - Ward and theatre staff described adjustments, which could be made for patients with learning disabilities. These included single rooms with facilities for relatives or carers to stay overnight, being first on the theatre list, relatives staying with patients until they had received their anaesthetic, being given greater time and aiming for consistent nursing staff.
 - We saw all patients had a board on the wall above each bed, which displayed key information about their care needs and included symbols indicating whether a patient had significant communication difficulties. The information displayed was discussed with patients and permission was sought.
 - All emergency admissions of patients over 75 years of age were screened for dementia as part of the admission process and as part of the commissioning for quality and innovation (CQUIN) for confusion assessment. There was one band four dementia practitioner at the hospital who was responsible for ensuring this information was captured. Once the information for the CQUIN had been captured this enabled the band four dementia practitioner to track where patients living with dementia were and offer support.
 - The dementia practitioner received a daily report from information services of all patients who had been admitted to the hospital in the previous 24 hours. They attended admissions wards, visited those aged 75 years, and over in line with national screening but also held a caseload of patients with dementia. The dementia practitioner then visited these patients to offer support, activities and enhanced care. The dementia practitioners reported to the nurse consultant for frailty and clinical educator for complex care.
 - Patients and carers were signposted and had access to charitable organisations for additional support and information.
 - Patient led assessment of the care environment audits (PLACE) are assessments carried out by local people going into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance, dementia and disability facilities . It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. The 2016 PLACE scores for LCH showed the hospital scored less than the England average for all six areas. However, facilities food, cleanliness and general building maintenance had improved scores compared to 2015.
 - All ward areas had bathroom and toilet signage in order that patients living with dementia could assist themselves to the toilet where appropriate.
 - Wheelchair access was good throughout the hospital. Disabled toilets were located at frequent intervals and were clearly signposted.
 - Departments at LCH were accessible however; on occasion patients might be expected to travel to other hospital sites for some treatments scans or consultations.
 - The trust used the national NHSe-Referral Servicesystem (previously known as choose and book) to assist patients in making, changing and cancelling appointments.
 - When attending the preoperative clinics all patients were given an information pack to take home with them which included pre-surgery high calorie drinks, information on quitting smoking (if requested) and advice specific to the type of anaesthesia and surgery they would be receiving. This was to ensure patients were as fit as possible prior to the surgery.
 - Staff told us it was possible for relatives to stay overnight; the patient would be nursed in a single room where a foldaway bed was available. This was a common occurrence for patients living with dementia or learning disabilities when relatives or carers stayed overnight in order to reduce anxiety and disorientation in the patient.
- ### Learning from complaints and concerns
- Posters and leaflets explaining how patients could complain were clearly visible around the hospital. Pre-operative information packs also contained information about how to make a complaint. The patient advisory and liaison service (PALS) was located in the hospital and leaflets were available for patients explaining how PALS could assist in managing complaints. Patients and visitors told us they would feel comfortable making a complaint, as nursing staff were approachable and understanding.

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- Between June 2015 and May 2016, there were 84 complaints in surgery services at this hospital. Themes included the communication, poor medical and nursing care or treatment.
- Ward managers were involved in investigating complaints in their areas. All staff we spoke with knew how to deal with complaints and concerns. Nursing staff told us they would try to resolve complaints quickly and locally whenever possible. Managers for the appropriate speciality produced action plans and identified learning. Managers shared learning from complaints through team meetings, safety briefings, newsletters and emails.
- We were given examples where staff had managed complaints locally and telephoned patients and their carers to discuss their complaint and the learning taken from them. We also saw boards in the ward managers' offices to collect information about compliments and complaints, which were then reported monthly to the complaints and compliments team for collation.
- We saw minutes of meetings highlighting to staff that poor communication was one of the top causes for complaint. Staff were encouraged to ensure patients understood when discussing care as a result of complaints.
- Following recent patient feedback noise at night had been identified as a concern. As a result agreed actions included the reduction of telephone volumes and the turning off lights. This had been cascaded to staff through the staff handover meetings

Are surgery services well-led?

Good



We rated well-led as good because:

- Governance and risk management arrangements were effective and as such able to protect patients from avoidable harm.
- There was a vision and strategy for this service, staff were able to describe this to us during our inspection.
- Staff were consistent in delivering care and demonstrating behaviours in line with the trust vision and values.

- Staff satisfaction was consistently positive with staff reporting good support at a local level. Staff were engaged and empowered to raise concerns where necessary.
- Staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt ward managers, matrons and heads of nursing were visible and provided a good level of support.

Vision and strategy for this service

- The trust had a five-year strategy for all clinical services for 2014 to 2019 to support the delivery of good quality patient care. The vision and strategy for surgical care was to provide comprehensive planned services, consolidated to avoid the pressures from emergency and unplanned care.
- For patients this meant the usual healthcare professionals for example the GP would manage planned surgery in the community. This would mean a more organised approach to admission and discharge planning to reduce actual hospital stay.
- During our meeting with the senior leadership team, we were told of plans to meet the vision and strategy for surgical care. Plans included, for example, increasing the nursing and medical establishments within surgery and the increase use of Grantham and Louth hospitals for elective and emergency pathways.
- The trust vision; working together to provide sustainable high quality patient-centred care for the people of Lincolnshire was underpinned by five key values; to be patient-centred, safety, excellence, compassion and respect. During our inspection, we saw staff demonstrated the trust's values in their day-to-day work, both when caring for patients and their families and when interacting with colleagues. During our focussed and unannounced inspections of the surgical areas, we saw dedicated staff, medical and nursing, who were committed to delivering high quality, safe care. We saw staff working together in managing the flow through the surgical emergency admissions unit (SEAU) and onto the other surgical wards.

Governance, risk management and quality measurement

- A risk register was held within surgery. Risks included a description, controls in place to mitigate the risk and, a summary of actions taken. Senior leads and ward

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managers had a good knowledge of the risks contained within this register and cited capacity, cancellations, referral to treatment times (RTT), staff skill mix and bed availability.

- Senior staff were able to identify their top risks, which included staffing, communication and delays and were seen in alignment with recorded risk.
- Governance arrangements and structure had been strengthened over the past year with monthly governance meetings and quarterly trust wide meetings. Risk management staff had been appointed to work proactively with wards with audit leads, matrons and the policy group to recognise and raise concerns.
- Each speciality held monthly quality and safety board meetings. We reviewed nine sets of meeting minutes and noticed good levels of attendance. However, there was no set agenda for all specialities to follow, each speciality discussed different topics, and we noted that some minutes were more in-depth and robust than others. Whilst some specialities discussed a breadth of areas such as incidents, complaints and compliments, audit, clinical effectiveness, best practice, risk register, education and training, other specialities clinical governance minutes were very brief.
- In 2015, we found no evidence of oromaxillofacial service (OMFS) involvement in clinical governance. However, we were provided with minutes from meetings, which assured us that the team now had governance processes in place.
- Quality and performance data was monitored through trust wide governance meetings that fed into the business unit performance review. The quality and safety dashboards were displayed within all ward areas. These highlighted information on falls, do not attempt cardio pulmonary resuscitation (DNACPR), sepsis compliance, tissue viability, nutrition, medication, venous thromboembolism, urinary catheter, peripheral catheter and dementia review.
- In 2015, the delivery plan for OMFS at LCH was under review by the Royal College of Surgeons (RCS). Some clinical procedures had been suspended and patients were referred to other regional trusts.
- The trust developed a 28-point action plan to address the concerns related to the RCS review. For example, continuing treatment of more complex cases at local trusts and the development of clinical leadership within the current team or with further consultant recruitment.

However, clinical leadership from within the team had been difficult to develop due to lack of substantive consultants in post and recruitment to the vacant positions had not happened.

- The medical director and the clinical director for head and neck services were fully aware of the on-going service reduction in OMFS and had engaged further assistance from a consultant OMF surgeon from another area to advise them further. The initial review produced in August 2016 highlighted committed experienced associate specialists, good team working within nursing teams and evidence of support from senior management. However, the on-going lack of substantive consultant posts was again identified along with engagement with appraisal and day case inefficiencies.
- We spoke with both the medical and clinical director independently. They both identified that recruitment of an experienced OMF surgeon to lead the service would enable development of the service strategy and completion of the RCS action plan. An action plan was requested from the trust after the August 2016 recommendations

Leadership of service

- Surgical services were provided at this hospital as part of the Lincoln surgical business unit. The business unit was split into four clinical directorates. These were surgery and urology, orthopaedics, theatres critical care and chronic pain and head and neck services.
- A clinical director, supported by a business manager and a head of nursing, led each clinical directorate.
- A band seven nurse, supported by a matron, provided local leadership on each ward.
- The sister on Clayton Ward had a ten minute “time to talk” session each day to discuss patient safety and risks for current patients. This was protected time to discuss each patient.
- The majority of staff told us they felt senior staff and managers were visible, approachable and supportive and they received appropriate support to allow them to complete their jobs effectively.
- We met with clinical managers who felt supported and engaged with the executive team. The majority expressing how proud they were with the changes the executive team were implementing.
- The majority of staff on wards and in theatres knew the chief executive and the chief nurse either from meeting them or from information shared through e-mails.

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- Junior doctors told us they felt supported and there was always a senior member of staff to ask for support.
- In 2015 leadership within OMFS was not effectively implemented or sustained. Despite the trust exploring many options to support the service with outside supervision and shared working, this remains the case due to difficulties with local recruitment.

Culture within the service

- The NHS Staff Survey 2015 saw the percentage of staff recommending the trust as a place to work or receive treatment as higher than the 2014 survey at 3.5%. This was slightly lower than the national average of 3.7%.
- Most staff felt respected and valued. All members of staff we spoke with were proud to work in the trust and they spoke positively about teamwork and the care they provided to patients.
- Staff conveyed a strong open and honest culture in all areas visited during our inspection.
- Staff told us they felt supported to report near misses, incidents and raise concerns to their line managers.
- The senior managers within the surgical division had high praise for their staff and recognised the challenges staff within the surgical division faced especially with the increasing demand on surgery.
- Staff felt supported to develop their skills and progress their careers. Many staff we spoke to had worked at the trust for many years, and had achieved career progression in clinical, nursing or management roles through education and support available from the trust.
- The significant tensions reported within OMFS in 2015 were no longer evident and the team were working together to provide a service despite the recruitment problems.

Public engagement

- Patients were able to give feedback on their experiences through the NHS Friends and Family Test (FFT). Results from the FFT were reported and discussed at the professional forums and meetings and within wards and teams. Patient experience, including compliments and complaints, and the results of the FFT were displayed within the wards on 'how are we doing' notice boards.
- There were patient information leaflets across the surgery wards and in every area; feedback cards were available for patients.
- The trust website and social media were used proactively across the service for patient feedback.

- The hospital was involved with the local area and we saw fund raising events and notices for future events to support the service.

Staff engagement

- Staff engagement was positive across all different staff groups within the surgical business units. Nursing staff spoke positively of being involved in ward decisions and new ways of working.
- Most clinical staff had monthly team meetings, which were minuted and provided relevant updates for staff on both department and wider trust information. Staff huddles at the start of the day also provided an opportunity for the dissemination of information to the staff.
- Nursing staff explained they saw senior staff every day and felt they were kept up to date. Without exception, all ward managers told us how their teams worked well together and supported each other in often very challenging circumstances.
- The trust recognised the hard work and contribution of their staff and publicly said thank you.
- Staff working at this trust were recognised for their contributions to patient care through the United Lincolnshire Hospitals NHS Trust (ULHT) staff awards. Each year, the awards provided a chance to recognise the work, dedication and care given by staff members and teams at the trust.
- The chief executive sent a weekly email blog to all staff. This included things such as vacancies, what was happening in the trust, information about national visits, award winning staff and health information such as the flu vaccine.







Innovation, improvement and sustainability

- There was a trust wide 'winter plan' that set out the organisations arrangements for the winter period. This plan recognised increases in pressure around winter, due to an increase in the clinical acuity of patients, capacity demands on resources within the trust and untoward events such as widespread infectious diseases including norovirus (sometimes known as winter vomiting bug) and the risk of the onset of pandemic flu. An influenza, or flu, pandemic happens when a new strain of flu virus spreads easily and quickly across the world.
- We saw a business plan "Key to Care" where educational opportunities to support professional development and

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revalidation for agency staff was proposed for every 75 hours booked in a one-month period, the trust provided seven and a half hours of continued personal development (CPD) credit for the individual to access training delivered free in the trust.

Maternity and gynaecology

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

Information about the service

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

Maternity services at Lincoln County Hospital (LCH) include the antenatal and postnatal clinic, the antenatal assessment unit, the labour ward (Bardney Ward) and antenatal and postnatal ward (Nettleham Ward). The gynaecology service offers inpatient services (Branston Ward), emergency assessment facilities, an early pregnancy assessment unit and gynae-oncology services (Hemswell Clinic). Outpatient services include colposcopy, hysteroscopy, and fertility management. A termination of pregnancy service is offered at LCH offering medical abortions and a very small number of surgical abortions.

Community midwives work across ULHT providing maternity services, including homebirth, antenatal and postnatal care over a large geographical area. Teams

worked in partnership with GPs, health visitors and children's centres providing lifestyle support and advice to women and families during pregnancy and following the birth.

The antenatal assessment centre has three rooms providing an assessment service. The induction bay has four beds and antenatal and postnatal ward (Nettleham Ward) has 26 beds located adjacent to the assessment centre. Four of the beds are located in side-rooms within the ward area, and one of the four bed bays includes the transitional care ward (for babies requiring closer monitoring). The labour suite (Bardney) comprises of eleven single rooms mostly with en-suite facilities, a three bedded observation bay used for recovery of patient's post-surgery, and two theatre rooms. One of the labour rooms has a water birth pool.

Gynaecology services are provided in the ward and treatment area. The ward has 18 beds incorporating a mixture of four bedded bays and side rooms for inpatients, and four treatment couches for early pregnancy and gynaecology attendances. The ward also incorporates two examination rooms and recovery rooms for the outpatient hysteroscopy service.

During our inspection, we visited all ward areas and departments relevant to the service. We spoke with 24 patient's, five relatives, and 32 members of staff including; senior managers, service leads, managers, midwives, consultants, doctors, nurses, anaesthetists, sonographers, support workers, administrators and domestics. A further 14 members of staff attended cross site focus groups. We reviewed 16 sets of medical records.

Maternity and gynaecology

Summary of findings

We rated this service as requires improvement because:

- The grading of incidents was not always consistent. Collection of data was also inconsistent across the service.
- Staff did not demonstrate learning from audits such as CTG audits or post-partum haemorrhage audits.
- The maternity dashboard data was not utilised fully. The data lacked red amber and green rating, which meant that staff could not assess the data against trust targets.
- Staff did not receive regular recovery training.
- Only 55% of non medical staff had received training in basic life support.
- Patient confidentiality could be compromised by the location of staff handover on Nettleham ward.
- There was no midwife led unit, reducing women's choice for a home from home environment.
- Sensitive patient groups were mixed within the gynae-oncology clinic and antenatal clinic.
- The lack of a dedicated elective caesarean section operating teams meant that in the event of an emergency women's surgery would be delayed.

However, we also found:

- Governance structures functioned effectively and interacted appropriately.
- Teamwork throughout the hospital was apparent and staff felt they were listened to.
- A strong business unit team had increased the visibility of the women's and children's business unit in the last 18 months.
- When something went wrong staff told us people received a sincere apology. Openness and transparency was encouraged.
- Staff were aware of their responsibilities for reporting incidents, and learning was shared.
- Medicines were stored safely with clean secure preparation areas.
- Clinical areas were clean and staff had made efforts to improve the environment for women.
- Staff performed multidisciplinary training in line with national recommendations.

- Womens' care and treatment was planned and delivered in line with current evidence-based guidance.
- Normal birth rates and still birth rates were better than the national average.
- A seven day antenatal maternity day assessment service was available for women with concerns or high risk pregnancies.
- Staff were caring and compassionate in the care they provided.
- The service had increased the number of trust wide specialist midwives. Some of these such as the bereavement midwife had not started.
- Women and families knew how to raise a concern and were treated compassionately when they did.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement



We rated safety as requires improvement because:

- Incidents were not always graded consistently.
- The maternity dashboard was not red, amber and green rated, or utilised to the greatest advantage. Data collection was not consistent and staff were not always familiar with it.
- Only 55% of non medical staff had received training in basic life support.
- Only two members of obstetric medical staff had attended annual multidisciplinary skills and drills training.
- We did not see evidence of a daily safety huddle performed to share information on the sickest, most at risk women or pressures across the units.

However, we also found:

- When something went wrong staff told us people received a sincere apology. Openness and transparency was encouraged.
- Reporting and follow up process for incident reporting was thorough and embedded in daily activity.
- Clinical areas were visibly clean although in need of modernising in places.
- Medicine storage had improved and was in line with recommendations.
- Safeguarding documentation was robust and information sharing effective. Safeguarding training was provided at level three for 84% of staff.
- Most of the time women received one to one care in labour. Although, staff were often moved around the unit to achieve this.
- Multidisciplinary emergency skills drills were performed weekly within the labour suite.
- Consultant obstetric cover on Bardney Ward (labour ward) was 61 hours a week, which was in line with Royal College of Obstetrics and Gynaecology recommendations of 60 hours a week.

Incidents

- All staff we spoke with understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses on the hospital electronic reporting system.
- There were 1141 incidents reported for maternity and gynaecology between July 2015 and June 2016. Seven incidents were classified as 'severe risk' and 95 as 'moderate risk'.
- Between August 2015 and July 2016 the trust reported no incidents which were classified as never events for maternity and gynaecology. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Weekly multidisciplinary IR2 (incident management reports stage 2) cross site meetings occurred. Action reports had been completed following a review of each incident, and learning was shared with staff via emailed minutes. If investigations identified practice issues Supervisors of Midwives, (SoMs) performed independent investigations and action plans. We saw examples of learning such as accurate documentation of the symphysis-fundal height (measuring the growth of the womb) to detect babies that are not growing.
- The rating of the severity of incidents was not consistent. For example, some third degree tears (significant perineal trauma during childbirth) were graded as moderate harm, and some as low harm. The risk management midwives told us they were working with staff on the principles of incident grading to address the inconsistencies.
- Risk team members and matrons, throughout women's and children services, read all moderate and severe incidents on a daily basis. Sometimes the severity of harm was altered at this point. A clear process to follow was laid out in the risk strategy with clear definition of roles and responsibilities.
- In a recent attempt to increase staff awareness of incidents they were included in the Women and Children's Midwifery and Nursing newsletter sent to all staff and placed in ward areas. Staff told us, and we saw a reporting timetable for feeding back to staff about the incidents they reported. This included an opportunity to recollect details, reflect and share information surrounding outcomes of any investigations.

Maternity and gynaecology

- Risk team staff and managers maintained a serious incident live tracker. These included both internal and external maternity and gynaecology reviews trust wide. At the time of our visit 44 incidents were being monitored, the oldest of these dated back to January 2015. This was due to an external investigation in place. We saw evidence that investigations were completed and that discussions with families took place.
- Band 7 nurses and midwives involved in investigations received training and support in performing them.
- Staff were able to give examples of changes in relation to incidents, such as careful monitoring of fluid balance in labour and were aware of the learning around accurate plotting of the fundal height.
- A perinatal and maternal mortality and morbidity presentation was held monthly and involved multidisciplinary team members (MDT). All cases presented by the medical staff had been through the risk management process. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. We reviewed the presentations from two of these meetings in May 2016 and July 2016 and saw that staff reviewed cases in detail, with areas of good practice highlighted, together with learning outcomes. These outcomes did not appear to be shared further than those attending the presentation.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patient's (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust had a duty of candour policy, and senior staff had a comprehensive understanding of this. Staff spoke about telling people when an incident or near miss had occurred. We reviewed IR2 minute meetings that contained actions but did not include duty of candour recommendations. Managers discussed cases where families were involved in creating information for parents following a bereavement.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at patient harms such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter

related urinary tract infections. Maternity and gynaecology services took part in this scheme. Data for this was collected on an identified day each month to indicate performance in key safety issues. Each ward displayed data around harm free care at the entrance to each ward area. Gynaecology and maternity recorded 97% to 100% harm free care for September 2016.

- The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. This is a system for reporting harm free care. The recommended areas of harm to be reported include; perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from the baby and psychological safety. Also included were admissions to neonatal units, and babies having an Apgar score of less than seven at five minutes after birth, (the Apgar score is an assessment of overall new-born well-being). This is a system of reporting on harm free care specific to maternity services. The maternity service did not take part in the maternity dashboard, but did collect some data. There were plans to start to use a new dashboard in October 2016.
- Staff completed a dashboard of information stating the percentages of events, including the maternity safety thermometer events. However, these were not RAG (red, amber, green) rated on the data provided by the trust. This meant they were not able to monitor their harm free care rates. Managers told us data was not reliable due to recent input errors and the dashboard had been altered in the last three months. Staff were not familiar with the data collected or the current levels such as induction of labour rates or third degree tear rates.

Cleanliness, infection control and hygiene

- The clinical areas we inspected were visibly clean. Some ward areas were however in need of repair. Cupboards within delivery rooms lacked doors (so could not be used for consumable goods), walls had damaged plaster which meant effective cleaning was not possible, and wipe clean surfaces had cracked and peeling worktops. Cleaning of corridors towards the obstetric theatre was made difficult due to the storage of sealed boxes along the corridor.
- There were hand gel dispensers on entry to all areas and also at the point of care. Appropriate signage regarding hand washing for staff and visitors was on display and we observed staff using the gel appropriately.

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- The hospitals bare below the elbow policy for best hand hygiene practice was adhered to. Staff had access to, and were seen to use personal protective equipment such as gloves and aprons.
- All wards and departments carried out hand hygiene audits every month. The audit looked at the World Health Organisation (WHO) five moments for hand hygiene. The audit focuses on five moments when hand hygiene should take place to prevent transmission. These are, before patient contact, before undertaking a clean or aseptic procedure, following an exposure risk, after patient contact and after contact with a patient's surroundings. Between January 2016 and June 2016 maternity and gynaecology achieved 97% to 99% compliance in the audits. Hand hygiene awareness initiatives included drop in and road show sessions trust wide, four monthly hand hygiene awareness weeks and the use of online training videos.
- Equipment had 'I am clean' stickers on them. These were visible and documented the last date and time they had been cleaned. This meant staff knew the equipment was clean and ready for use.
- Curtains around bed spaces were disposable with dates when put up, and when a change was required.
- There were reliable systems in place for the management and disposal of clinical waste and sharps in accordance with the trust policy.
- The trust reported no cases of Meticillin Resistant Staphylococcus Aureus (MRSA), Meticillin Sensitive Staphylococcus Aureus (MSSA) or Clostridium Difficile (C. Difficile) infection for maternity and gynaecology services for the reporting period April 2016 to July 2016. MRSA is a bacterium responsible for several difficult-to-treat infections. MSSA differs from MRSA due to antibiotic resistance. C. Difficile is an infective bacteria that causes diarrhoea, and can make people very ill and is associated with antibiotic usage.
- The hospital reported and investigated all readmissions for surgical site infections. In gynaecology between July 2015 and June 2016, only one readmission was reported with a surgical site infection.
- Staff accessed mandatory infection prevention control training through an e-learning package. The average compliance for staff across the trust was 74%. This was worse than the trust target of 95%. The compliance rate for medical staff was 82%, and data for non-medical

(nursing, maternity and healthcare) staff showed 84% of maternity staff and 98% of gynaecology staff had completed infection prevention and control online training.

Environment and equipment

- Doors to gain entry to the ward areas were locked and staff gained entry and exit via a swipe card system. CCTV cameras were in use in all areas. Reception staff assisted during busier times by answering the door. An abduction policy was in place, although staff could not recall performing an abduction exercise drill.
- Actions had been taken to improve the environment within Branston gynaecology ward and some areas of the maternity department. For example, two bathrooms within maternity wards had been made into wet rooms. However, in two toilets in delivery rooms pregnant women would find it difficult to enter and close the door because clearance between the door and toilet was minimal.
- Throughout the unit staff reported sinks and toilets blocking due to the age of the plumbing and drainage and the use of maceration toilets. We witnessed several toilets not in use due to blockage. When a flood occurred areas would be isolated for up to a week at a time due to the risk from asbestos within the building. This was on the risk register and information was supplied to staff on the risks of asbestos.
- The trust had developed a 'decamp' ward to enable work to progress in the affected areas. At present, this was in use by the neonatal unit. A business plan had been written to address key priorities and improve the physical care environment of the maternity areas.
- Checking and documentation for adult resuscitation equipment and neonatal resuscitaires (a warming platform used for clinical emergencies and resuscitation) on Bardney Ward were inconsistent. We saw checklists had signatures missing 25% of the time for August 2016 and September 2016. The checking system required staff to sign in two places. Staff told us they checked each resuscitaire before use. We checked six partograms (labouring women's notes) and the resuscitaire check box had been completed. No incidents had been reported of resuscitaires being unfit for use. We observed that equipment and consumables stored on the resuscitation trollies were sterile and within their expiry date. This meant safety equipment was readily available in the event of an emergency.

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- Within Nettleham Ward, Branston Ward, Hemswell and clinics areas in both maternity and gynaecology, emergency equipment was checked consistently, with items appropriately packaged, stored and ready for use. All equipment we looked at had been routinely checked for safety with visible safety stickers demonstrating when the equipment was next due for service. This included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Staff were aware of the process for reporting faulty equipment.
- Most staff told us that adequate equipment was available to run the service safely. We looked at cardiotocography (CTG) equipment on the delivery suite. CTG equipment is used to monitor a baby's heart rate and a mother's contractions while the baby is in the uterus. The CTG equipment we looked at was clean and had been checked and labelled when the date of the next maintenance check was due.
- Staff explained that only one waterproof 'telemetry' CTG machine was available. The telemetry machine enables greater movement for the women and those deemed of higher risk to use the birthing pool.
- There were pool evacuation nets for water birth evacuation in the pool room on the Labour Ward. Training for pool evacuation had been given to staff supporting women having a pool birth. Staff signed a document within the pool room to confirm they had received pool evacuation training.
- Storage facilities throughout the department were limited, and trollies and equipment were stored in corridors. This did not appear to compromise access but due to the height and number of boxes stored, cleaning would be difficult due to the height of the trollies.
- A review of the emergency obstetric theatre had been performed by the local Clinical Commissioning Group (CCG). They highlighted areas for improvement to provide a safer clinical environment. areas.
- We checked medication cupboards and ward trollies. Intravenous fluids were stored in locked rooms in all areas and fridges used to store medicines were locked, which meant they were protected from the risk of being tampered with. Since the previous CQC inspection in 2015, a lockable drug storage and preparation room had been completed on Bardney Ward. This allowed staff to prepare and check medications in a clean, undisturbed area. The room however had minimal ventilation, and no thermometer to monitor room temperature. This meant that intravenous fluids could be stored above safe temperatures. When we returned for the unannounced visit a thermometer had been installed and the temperature was being monitored.
- We found emergency drugs stored in unlocked boxes next to the relatives waiting area. When escalated to staff it was moved to the drug preparation room and all staff informed.
- The hospital used paper prescription and medication administration charts for women. A pharmacist checked medicine prescription charts, and the checks recorded in green ink on the prescription charts to help guide staff in the safe administration of medicines.
- We saw appropriate arrangements were in place for recording the administration of medicines. The records were clear and fully completed. The records showed women were getting medicines when they needed them, and any reasons for not giving women their medicines were recorded. This meant women were receiving their medicines as prescribed. However, women's weights were not always recorded on drug charts. This meant that weight dependant medications were prescribed without a recent weight. We saw midwives using an early pregnancy weight due to the lack of admission weight monitoring.
- If women were allergic to any medicines this was recorded on their prescription chart.
- Within the termination of pregnancy service, a doctor prescribed all abortifacient medicines. Drugs that induced abortion were only prescribed for women undergoing medical abortion following completion of a face-to-face consultation with a member of the nursing team.

Medicines

- Medicines were managed, stored and administered appropriately. Controlled drugs (CDs) were stored appropriately in all of the clinical areas we inspected. CDs are medicines which have extra security controls over them. They are stored in a separate cupboard and their use recorded in a CD register.

Records

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- Women's care records were in paper format and used trust wide. Staff stored medical records securely in restricted areas or in lockable trolleys in clinical areas in line with data protection policies.
- Women's using the maternity service were provided with their own set of hand held care records to bring into the hospital with them. The hospital also held medical records relating to each woman. Staff told us notes were readily available throughout pregnancy and for planned gynaecological admissions. Notes were often large with loose pages that could fall from the folder and become lost.
- Child health records known as 'red books' were given to mothers for each new born baby following the completion of new-born and infant physical examinations.
- Midwives performed maternity records audits in conjunction with supervisory interviews and mandatory training. This included learning actions such as accurately documenting in notes CTG classification every hour. Between April 2016 and June 2016, if there was any deviation from the classification of 'normal', the date, time and signature review was not recorded on the trace and in the notes in 42% of the notes reviewed. In the same period, all notes lacked documentation of management plans and appropriate actions taken if care deviated from the normal path. The audit included 16 sets of records.
- On Nettleham Ward all staff completed an SBAR form (situation, background, assessment, recommendation) to handover information. This ensured information giving was clear concise and relevant. This was signed on each handover of care.
- The postnatal notes included risk assessments for the community midwives and gave concise information from the pregnancy.
- We reviewed 16 sets of notes throughout maternity and gynaecology, the named midwife or nurse leading the women's care was documented. Records were legible, dated and signed with clear plans of care. All records were multidisciplinary and we saw where nurses, midwives, doctors and allied health professionals including physiotherapists had made entries.
- Notes for women who had delivered by elective caesarean section were loose leaf and at times did not all contain the same documents. For example, some packs included the recovery checklist, in two out of six records checked it was either absent or incomplete.

- Risks to women, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools incorporated into care plans.

Safeguarding

- The head of midwifery was the named midwife for safeguarding. The trust had recently appointed a named safeguarding lead for maternity across the two sites. The specialist midwife worked Monday to Friday from 9am to 5pm.
- Staff we spoke with knew about the trust's safeguarding process and were clear about their responsibilities. Many had experience of safeguarding incidents and felt supported in practice.
- Display boards around the ward areas gave comprehensive information on safeguarding including Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 information. Contact numbers were visible to staff for further support.
- Safeguarding children and young people: roles and competences for health care staff Intercollegiate document 2014 states that all clinical staff working with children, and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child, where there are safeguarding concerns should have level three training. Training data received during the inspection identified that 84% of staff across women's and children's business unit had received level three training. This did not meet the trust target of 95%. Within Branstons Ward, 100% of clinical staff including healthcare assistants had received their level three training. Training included advice on female genital mutilation (FGM is the practice, traditional in some cultures, of partially or totally removing the external genitalia of girls and young women for non-medical reasons) and child sexual exploitation (a type of sexual abuse). This training was provided for all grades of clinical staff.
- Staff within the termination of pregnancy clinic understood their responsibilities including referring to social services young people under the age of 16 and speaking to women alone to establish there were no risks of coercion.

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- The electronic safeguarding database had improved communication of concerns and plans. Staff were able to check throughout the hospital if safeguarding plans were in place. We saw evidence of this working well and staff updating both paper and electronic records.
- The FGM guidelines were tailored around the mechanisms of FGM and did not refer to safeguarding, which is not in line with Department of Health May 2016 guidance. The guidelines have recently been amended to incorporate this.
- Safeguarding supervision had recently improved to a more formal system. This was due to be performed every three months.

Mandatory training

- Mandatory training included moving and handling, infection prevention, equality and diversity, information governance, conflict resolution, basic life support and safeguarding vulnerable adults and children. Safeguarding training was provided at an appropriate level depending on the requirements of the staff group.
- Data provided by the trust demonstrated that compliance across women's and children's services for mandatory training was 88%, although trust basic life support (BLS) training for medical staff was at 41%. Trust data demonstrated that only 55% of non- medical staff had completed BLS training.
- Data held within maternity demonstrated that 93% of midwives had completed BLS training. The hospital was worse than the target for all staff groups in nine out of ten courses.
- The ward sister on Branston Ward had started ward training in basic life support to improve compliance. This was performed with support from the resuscitation training department. They performed ad hoc one to one sessions if necessary.
- Maternity staff described attending yearly multidisciplinary skills and drills training. This included; maternal and neonatal resuscitation, electronic fetal monitoring, management of obstetric emergencies, recognition of the severely ill pregnant woman, sepsis training, manual optimising normal birth, antenatal and new-born screening, infant feeding, diabetes and weight management. Maternity data for June 2016 demonstrated 93% of midwives had attended this training. Although described as multidisciplinary and supported by medical facilitators, only two members of

- obstetric medical staff had attended skills and drills sessions. Practice development staff told us that medical staff had booked themselves onto subsequent sessions.
- Practical skills and drills sessions were run weekly within the maternity department. A newly appointed band seven practice development midwife supported these. Attendance was not monitored due to the ad hoc nature of these.

Assessing and responding to patient risk

- Staff on Branston Ward completed comprehensive risk assessment care plans for all women. These include National Early Warning Scores (NEWS, used to assess the health and wellbeing of women who were identified as being at risk), malnutrition universal screening tool (used to identify adults at risk of malnutrition), and pressure ulcer assessments. The care plans included details in continuing care, such as fluid balance charts, catheter management and cannula care. A sepsis screening tool was also included in the booklet, with a sepsis six prompt for escalation purposes.
- Maternity care plans were in a booklet form which could be increased in the event of obstetric emergency. The Maternal Early Warning Score (MEWS) was used to assess the health and wellbeing of women who were identified as being at risk. We observed appropriate escalation of a woman's condition due to a rise in the MEWS score. We checked 16 sets of notes and found these had been completed and scores were calculated. The hospital staff completed observation assessments, on new-born infants using the Neonatal Early Warning Scores.
- Babies undergoing new-born observations were cared for on transitional care (an area of the ward where babies requiring a higher level of care are looked after with their mothers) on Nettleham Ward, supported by staff from the neonatal unit.
- A critical care outreach team was available seven days a week between the hours of 8am and 8pm to support staff with women who were at risk of deteriorating. We observed early referral and good communication with the outreach team of a woman requiring a greater input of care due to her deteriorating condition.
- Venous thromboembolism (VTE) assessments were completed for all women during pregnancy and on admission to the hospital.

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- There were arrangements to ensure that checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion in obstetric theatres of the Patient Safety First's Five Steps to Safer Surgery – an adaptation of the World Health Organization (WHO) surgical safety checklist.
 - We observed the theatre team completing the Five Steps to Safer Surgery throughout the sign in, before induction of anaesthesia and at the sign-out as the woman left theatre.
 - An audit of the WHO checklist for the period August 2015 to July 2016 (sample size 103 sets of records) showed that within obstetrics and gynaecology, the WHO checklist was present in 90 out of the 103 (87%) sets of notes. It demonstrated that 95% of these records had 'sign-in' documented 95% documented 'time-out' against a target of 100%.
 - During the initial booking appointment, pregnant women were given hand held maternity notes which supported antenatal care. Midwives took a full medical, obstetric, social and family history, which included an assessment of emotional well-being. This assessment was used to classify whether the woman was at low or high risk. Low risk women continued with midwifery-led care, whilst high risk women received consultant-led care. This assessment was repeated at 36 weeks gestation to enable discussions of intended place of birth, and again when being admitted to delivery suite, at a home birth or if there were any changes in pregnancy.
 - A triage of care was in use in the antenatal day assessment unit. Pregnant women who called for advice received a telephone triage to establish the appropriate location of care. On arrival staff triaged women in order to see the most urgent cases first. Procedures were in place to ensure that women with reduced fetal movements received monitoring within 30 minutes of arrival.
 - A multidisciplinary handover took place on labour ward twice a day. This gave staff the opportunity to highlight the sickest women and areas of concern around the unit.
- and Care Excellence (NICE) Safe Midwifery Staffing, 2015. (Birth-rate plus is a tool used to calculate midwifery staffing levels, based on the ward acuity and needs of the women's. Acuity is the measurement of the intensity of nursing care required by a woman). Data provided by the trust demonstrated that on average 46% of the time, there were periods when staffing levels did not meet acuity. Staff described and we saw the redeployment of staff to meet the service needs. In the event of high acuity an escalation process was in place. Staff from the community would support their colleagues for a period of time (not exceeding four hours). Between May 2016 and September 2016 community midwives were used to support the unit ward on 61 occasions.
- The serviced utilised the NICE 'red flag' system that alerted when womens' safety was compromised due to staffing issues for example delay in suturing or not achieving 1:1 care in labour. We saw evidence of staff moving once or twice during a shift to increase staffing levels in areas that were short staffed.
 - The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Midwives 2007), based on the expected national birth rate, was one whole time equivalent (WTE) midwife to 28 births. Lincoln County Hospital (LCH) maternity midwife to birth ratio was currently 1:28, which was the same as recommendations.
 - As of June 2016, LCH reported a vacancy rate of 9.6% for maternity wards based on a vacancy rate of 7.7 WTE, 14.8% for antenatal clinic (0.9 WTE), and 3.7% for community. This was based on 2.2 WTE vacancies. Funding was being redistributed to employ a new infant feeding co-coordinators post.
 - At LCH the Maternity and Gynaecology wards had an average sickness of 5.4% the number of WTE days lost was 1247. This was slightly worse than the trust average of 4.7%.
 - Due to sickness and maternity leave, planned versus actual staffing rates for June 2016 were short in many areas. This was particularly apparent with the rotational midwives supporting Bardney Ward, Nettleham Ward and antenatal clinic. During March-June 2016, actual staffing figures for rotational midwives was 12 WTE staff less than the planned figures over the four months. Bank staff were used to bridge the gaps in staffing figures. Staff reported that they were becoming tired and described feeling 'flogged' from working extra shifts

Midwifery staffing

- The maternity department used the National BirthRate Plus acuity tool to calculate midwifery staffing levels, in line with guidance from the National institute for Health

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and being short staffed for periods of time. Many also attributed this to working 12 hour shifts. These had caused mixed reviews when introduced approximately three years before. Eight newly qualified midwives were due to start at the end of October 2016.

- Women told us, in the postnatal period, they were often cared for by several midwives in one shift due to staff moving from Nettleham Ward to Bardney.
- From April 2015 to March 2016, Lincoln County Hospital reported a bank and agency usage rate of 3.1% in the Maternity and Gynaecology wards. This was better than the trust average at 11.1% bank and agency staff. Staff doing extra shifts mostly filled vacant shifts. A bank staff closed social media group had been developed to advertise vacant shifts. Staff told us this had helped with the planning of shifts. A bank induction process was in place. Bank staff received a monthly flyer reminding them to organise mandatory training and training such as commode cleaning video links.
- Electronic staff rostering was in use, staff felt it lacked flexibility due to the number of shifts rostered and staff requests. It did however mean that staff could claim their time owing back via the electronic record. On Bardney Ward alone, in September 2016 staff recorded 116 occasions when they did not get a break or left the shift late. Managers attributed this to the twelve-hour shifts and giving staff responsibility for organising their own breaks. Staff hoped that the new staff starting in October 2016 would help with staffing issues.
- Between April 15 and March 16 the turnover rate for the hospital based midwifery staff was 12.4% this was based on 11 WTE leavers.
- Staffing levels were displayed in all the clinical areas we visited and we saw information displayed indicated actual staffing levels mostly met planned staffing levels.
- Shifts on Bardney Ward were mostly led by a band seven co-ordinator. The co-ordinator tried not to be responsible for the care of a labouring woman, although had to care for non-labouring women at times.
- Between July 2015 and June 2016, 88 incidents were reported involving staffing. These were all due to the lack of suitably trained staff and all classed as low or no harm incidents. Many of these incidents highlighted that the escalation process had been commenced in accordance with unit policy.

Nursing Staff

- Branston Ward incorporated the gynaecology assessment ward and were staffed together. There were two nursing vacancies, and bank and agency staff were used to cover shifts.
- Planned versus actual staffing levels were displayed at the entrance to the ward.
- Nurses and midwives in charge of the shift on the maternity and gynaecology wards took a caseload of women, but would reduce this to manage the demands of the ward.
- Supernumerary periods for new staff were tailored to staff needs. A new matron was in place to support trust wide gynaecology services. Staff expressed that this gave gynaecology greater direction and leadership.

Medical staffing

- Obstetric consultant cover was 61 hours a week shared between ten consultants. This was in line with Royal College of Obstetricians and Gynaecologists (RCOG) 2007 guidelines, which recommends that a unit which has between 2500 and 4000 births a year requires 60 hours of consultant presence.
- Recent changes had increased the continuity of consultant presence on labour ward by consultants working a 'hot week'. This meant that the same consultant was present 9am to 5.30pm Monday to Friday. Staff explained that the reduced frequency of changing consultant ensured better continuity for women.
- Branston Ward consultant gynaecologist cover was 8.00am to 6.00pm.
- Overnight consultants worked a non-resident on-call system allowing them to be up to 30 minutes of the hospital if required.
- Between April 2015 and March 2016, Lincoln County Hospital reported a vacancy rate of 18.5% in maternity and gynaecology; this was based on 5.0 whole time equivalent vacancies. However this improved in July 2016 and at the time of inspection in October 2016 the vacancy rate was 3.7%.
- In Lincoln County Hospital the Maternity and Gynaecology wards had an average of 2.57% sickness rate, the number of FTE days lost was 230.
- Dedicated anaesthetic cover was provided twenty four hours a day with an on call anaesthetist available to cover for women who needed to go to theatre.

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- From April 2015 and March 2016, Lincoln County Hospital reported a bank and locum usage rate of 20.0% in the Maternity and Gynaecology wards. Gynaecology did not use any locum doctors.
- Multidisciplinary ward rounds occurred on the gynaecology ward every morning Monday to Friday. Junior staff described good support although shifts were often extremely busy.
- Weekends and out of hours senior house officers provided cover for Nettleham Ward, day assessment unit, Branston Ward, EPAU (early pregnancy assessment unit) and emergency gynaecology unit. Staff told us women's reviews were often delayed due to this.

Major incident awareness and training

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

Are maternity and gynaecology services effective?

Requires improvement



We rated effective as requires improvement because:

- Monitoring of patient outcomes statistics on the maternity dashboard, such as the percentage of women who had severe tears, was not taken into account to improve practice. This also meant that staff could not assess the data against trust targets.
- Recovery guidelines stated that yearly updates were required for all staff involved in the recovery of women. Only 15 midwives were documented to have received once only recovery training.

- The fetal monitoring guidelines did not have an addendum highlighting the delay in following current guidelines.
- Many of the audits did not provide plans for presentation of findings to colleagues or current timelines.
- Staff providing counselling prior to termination of pregnancy had not received accredited counselling training.
- Multidisciplinary maternity emergency skills drills were completed annually by all staff. Midwifery compliance at these sessions was good but only 9% of medical staff had attended. This did not comply with National Maternity Review (2016) recommendations.
- The service held both cardiotocograph (CTG) training and meetings to review and discuss CTGs. Although 94% of midwives had completed CTG training, only 21% were able to attend the meetings due to difficulties leaving the ward during a shift.

However, we also found:

- Women's care and treatment was planned and delivered in line with current evidence-based guidance.
- Regular audits of practice were performed to review services such as fetal monitoring and epidural provision.
- Normal birth rates and still birth rates were better than the national average.
- Practical obstetric multidisciplinary training was provided for all staff in maternity services. However, uptake by medical staff was improving but were still poor. Midwifery training rates were 94%.
- A seven day antenatal maternity day assessment service was available for women with concerns or high risk pregnancies.
- A new electronic records system was in the process of being developed, including employment of an IT midwife.
- Staff received meaningful appraisals and role development programmes were in place.
- On discharge from hospital women were given clear information documented in post-natal booklets.
- Staff were aware of their roles within mental capacity and catering for individual needs.

Evidence-based care and treatment

- The care of women using the services was in line with Royal College of Obstetrics and Gynaecology (RCOG) guidelines (including 'Safer childbirth: minimum

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standards for the organisation and delivery of care in labour'). These standards set out guidance about the organisation, safe staffing levels, staff roles, education, training and professional development.

- Trust wide policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. Within gynaecology, the care of women requesting induced abortion (RCOG) and the Department of Health, Termination of pregnancy for fetal abnormality guidance was also followed.
- We reviewed 11 clinical guidelines; these were all easily accessible, in date and version controlled. Apart from the electronic fetal heart monitoring guideline, all guidelines we reviewed, referenced current up to date guidance from NICE, RCOG or equivalent.
- A trust wide maternity policy and guideline group had been set up. They were responsible for meeting bi-monthly to review and ratify maternity guidelines. We saw a set of minutes that highlighted discussion around guidelines and guidelines planned for the next meeting.
- Within the trust, guidelines for electronic fetal monitoring had been delayed following a NICE surveillance review of Intrapartum Care CG190. The group had decided not to ratify the new guidelines until rerelease by NICE in November 2016.
- The gynaecology unit followed appropriate guidance for the disposal of fetal remains. Women consent for preferred method of disposal was gained prior to the start of a termination of pregnancy in accordance with RCOG guidance.
- The trust did not have clinical guidance in use for womens receiving outpatient hysteroscopy (a procedure used to examine the inside of the uterus). This meant that we could not confirm that RCOG Best Practice in Outpatient Hysteroscopy was being followed. Medical staff assured us that this was the case.
- There was evidence to support NICE Quality Standard 37 guidance was being met. This outlines the expected standard a woman and her family, may expect to receive during the postnatal period. For example, we observed that women were advised, within 24 hours of the birth, of the symptoms and signs of conditions that may increase the risk of harm and require them to access emergency treatment. These details were included in the postnatal booklet.

- Womens with risk factors for gestational diabetes were identified and offered glucose tolerance testing in line with the current NICE guidelines.
- We reviewed seven fetal heart rate monitoring records. In all records, staff had made an hourly documented systematic assessment of mother and baby in accordance with national guidelines. The trust performed monthly audits of CTG monitoring. A quarterly analysis of the audits highlighted good and poor practice. The midwives update day included learning from audits. Weekly CTG review meetings occurred to discuss interesting or challenging traces.
- An audit programme was in place for a range of service wide audits. Many of the audits did not possess timelines including presentation of finding dates, despite 33% being ongoing audits. This meant that staff were unfamiliar with the outcomes of the audits. We were told a greater structure would be added by the guideline and audit midwife.
- Data provided by the trust demonstrated changes to practice to monitor post-partum haemorrhage (PPH, severe bleeding after delivery) more closely. This was an action from the ongoing PPH audit.

Pain relief

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

Nutrition and hydration

- Fluid balance charts were completed and legible. These were used for all women in labour and according to risk within gynaecology.

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- Women were encouraged to make an informed choice on the best method to feed their baby. The service was awarded UNICEF level two Baby Friendly Initiative. The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding.
- Between September 2015 and June 2016, the service's breastfeeding initiation rates were 69%, and 60% on discharge from hospital. Data was not currently collected on the percentage of women breastfeeding on discharge from maternity care.
- The trust did not currently have an infant feeding co-ordinator. Staff all received training on supporting women with breast feeding. However, there was not a nominated member of staff for coordinating training and monitoring staff competencies.
- The Malnutrition Universal Screening Tool (MUST) was used to screen women for their risk of malnutrition throughout gynaecology. We looked at nursing records and found five out of six forms had been completed. Fluid balance charts were used appropriately to record fluid intake and urine output.
- A choice of meals was available and women completed menu choices for the day.
- Women told us the meals were served on time and were acceptable.
- Expressed breast milk was labelled and stored safely in accordance with trust guidelines.

Patient outcomes

- United Lincolnshire Hospital Trust (ULHT) used a maternity dashboard as recommended by RCOG (2008). Monthly figures of clinical outcomes before, during, and after delivery were collected and reported jointly on across both Lincoln County Hospital and Pilgrim Boston Hospital. This is thought to help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care. The RCOG guidance states 'Individual maternity units should set local goals for each of the parameters monitored, as well as upper and lower thresholds'. The data received from the trust did not have red, amber, green (RAG) rating on it. This meant that staff could not assess the data against trust targets. There would be the risk that staff would lose oversight of the risks. For example, the trustwide rate of failed instrumental (assisted) deliveries that resulted in emergency sections peaked at 11.4% in January 2016, but stayed between one and six percent for the next six months. The lack of RAG rating meant the peak was not highlighted. Staff told us that the data had only been collected for a few months and they were not familiar with both the collection and the patient outcomes. However, information provided by the trust included eight months of trust wide data. A new RAG rated dashboard was in development. This was discussed at speciality governance meetings.
- Trust wide, between April 2015 and March 2016, 60% of babies were born normally, which was the same as the England average. In the same period trust wide, caesarean section figures were the same as the England average at 26%.
- Managers told us all cases of emergency caesarean section were reviewed by medical and midwifery staff.
- Between April 2016 and June 2016, the hospital forceps and ventouse (assisted instrumental delivery) rate was 19.9% which was worse than the trust target of 10 to 15%.
- The induction of labour figure across the trust was similar to the trust target of 30% of pregnancies.
- The dashboard was not displayed in staffing areas but was on the agenda for the obstetrics and gynaecology governance meeting. It could not be established if the effectiveness of care and treatment was routinely discussed.
- An audit and policy lead midwife had been employed to give focus to the audits performed. The plan was that once she had reviewed the audits there would be an improvement in the use of the evidence created.
- We saw trust wide data submitted to national data collection, such as stillbirth rates and National Obstetric Anaesthetic Database. A trust wide audit of data collected between July 2015 and November 2015 demonstrated that 88% of labouring women received an epidural within 30 minutes of their request. This highlighted a need for closer communication between anaesthetists and midwives. A re-audit was planned the following year.
- The anaesthetic team also audited the frequency of accidental dural puncture and post dural puncture headache rates. The audit highlighted that the feedback paperwork was not adequate and that getting feedback from women was challenging. Plans were in place to send womens contact details if problems occurred in order to capture all women who suffered complications post epidural or spinal anaesthesia.

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- For the period January 2015 and December 2015 the hospital stillbirth rate was 3.8 per 1000 births. This is less than the national average of 4.7 per 1000 births. The trust benchmarked their rate and practice against other trusts and national guidance to ensure practice was up to date. All still births were reviewed by appropriate staff and presented at governance meetings. The trust had not fully implemented the Saving Babies Lives Care Bundle (2016). They had identified the need and planned a phased approach.
- In 2016 National Neonatal Audit Programme (NNAP), LCH was below standard for four out of five indicators. However, LCH was not an outlier in any of the standards nationally or within the Trent Perinatal Network.
- Data provided by the trust demonstrated that between April 2014 and March 2015 544 full term babies were admitted to the neonatal intensive care unit. This figure was 56% of their unexpected admissions to NICU (962 babies).
- National antenatal key performance indicators (KPI) were reported electronically for screening in pregnancy data. The antenatal KPIs not achieved in 2015, were the referral to gastroenterology services for hepatitis B positive women within 6 weeks of receipt of the positive result. The second was the completion of request forms for down's syndrome tests. Action plans were in place to address these areas.
- For new-born KPIs, the trust also achieved four out of six indicators. A report highlighted a significant improvement in the two KPIs not achieved. Only 2% of babies had received a repeated new-born bloodspot screening test, compared to 4% previously. Work was still ongoing to provide support and training for staff that persistently need their tests repeating.

Competent staff

- New starters were given an induction period incorporating mandatory training. This was initially for a month but adjusted to suit individual staff needs.
- A preceptorship package was available for the newly registered midwives that were due to begin in October 2016. We were told that study days would also be provided for the new starters.
- One whole time equivalent (WTE) band seven practice development midwife worked across both sites. Each site also had clinical educators to offer support. A band six development programme was in place to support staff working towards a band seven position. We

received mixed reviews of the process, with some staff feeling it gave opportunity, and others who were a quarter of the way through the year long programme had not received support or mentoring. Staff told us that work constraints restricted the opportunities to attend governance meetings and development opportunities. There had been increased demands on staff due to sickness and maternity leave.

- Several midwives had undertaken the New-born and Infant Physical Examination course so they could discharge low risk babies following birth. The framework within which they practised was clear including a detailed list of neonates (babies up to 28 days old) they could review and those who needed referring to a neonatologist.
- A new matron for gynaecology across the trust was planning to implement more leadership opportunities, and increase training modules for the nursing staff. This included rewriting job descriptions for the specialist nurse posts and developing suitable staff for seconded management roles.
- Practical obstetrics, multi-professional skills drills training was developed for the maternity services. This is an accepted format by which healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies, for example haemorrhage, maternal collapse, and resuscitation of the new-born. Obstetric anaesthetic staff supported the multidisciplinary training.
- Staff received updates in caring for women whose condition was deteriorating, in caring for women with an epidural, and had anaesthetic recovery training and competency assessment. This complied with the recommendations by the British Anaesthetic and Recovery Nurses Association (2012) to recover women following anaesthesia. However, data received from the trust demonstrated that in July 2016, of the 117 hospital midwives, only 15 were recorded to have undergone the training. Staff told us they spent a single day in recovery for training. The recovery policy did state that a three yearly update must be performed. The midwifery clinical educator told us that recovery training was included in the preceptorship package for newly qualified midwives. The hospital had practice clinical educator posts working in both maternity and gynaecology.
- There were 21 supervisors of midwives (SoMs) across ULHT. This equated to a supervisor to midwife ratio of

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1:14.9, in line with the national recommendation of 1:15. SoMs help midwives provide safe care and were accountable to the local supervising authority midwifery officer (LSAMO). All midwives had a named supervisor of midwives (SoM). Staff said they had access to and support from a midwifery supervisor. They reported the process was very similar to the annual performance review.

- The local supervising authority (LSA) had audited the SoM service and had produced a report with a number of recommendations for improvements. The SoMs had an action plan to raise awareness of the role of the supervisors and were performing a greater number of supervisory decision trees (a review of clinical incidents). The SoMs told us they had a process in place for allocation of investigations, although staff said they could be slow to complete.
- Data for the Women's and Children's business unit demonstrated that in July 2016 78% of staff at Lincoln County hospital had received an appraisal this year. All ward areas we visited had boards in offices with appraisal rates and dates due highlighted. The appraisal and training rates were on the agenda for the ward sister confirm and challenge meetings with the head of midwifery. All staff we spoke to had received an appraisal in the last year.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They said they had good ward-based teaching, were supported by the ward team and could approach their seniors if they had concerns.
- Multidisciplinary maternity emergency skills drills were completed annually by all staff and ad hoc sessions were performed on Bardney Ward weekly. Midwifery compliance at these sessions was 95%, but in July 2016, 9% of medical staff had attended. This did not comply with National Maternity Review (2016) recommendations.
- Training included cardiotocograph (CTG) training and meetings. A greater proportion of medical staff than midwives attended the meetings, with 50% of medics attending and 21% of midwives. However, 94% of midwives had completed the CTG training sessions. Staff told us this was due to difficulty in leaving the ward during a shift.
- Nurses had not completed gynaecology specific modules but described learning opportunities beyond

registration (LBR). Some staff had been able to partially complete degree modules with the help of LBR funding. Training for gynaecology-oncology nurses was planned via charitable organisations.

- Not all staff supporting women undergoing termination of pregnancy had approved counselling qualifications. They had received training in performing assessment of consent for the procedure.
- RCOG Safer childbirth minimum standards recommends that all midwives are trained and regularly assessed as competent in neonatal basic life support. Data for July 2016 demonstrated that 94% of staff had completed their training. This was similar to the trust target of 95%.
- Healthcare support workers were trained to work alongside members of staff supporting each other in performing and documenting women's observations. Each ward kept a record of the staff competencies.

Multidisciplinary working

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

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- The optimising birth group was made up of both midwifery and medical staff in a deliberate attempt to work together to achieve the optimal birth experience for womens.
- Electronic summaries of care were sent from hospital to health visitors and GPs. Following a termination of pregnancy women were given a detailed discharge letter and prescription for contraception, or advice and signposting if she was undecided on her chosen method of contraception.
- We saw MDT discussions between midwives, anaesthetists and outreach team for a woman who was showing signs of deteriorating health.
- Community midwives reported that having a base within the hospital meant they could find medical staff for support when necessary.
- Babies requiring additional care such as observations or antibiotics were cared for in one of the transitional care cots within Nettleham Ward. Midwives and nursery nurses worked together to provide a holistic approach to care for mothers and babies.

Seven-day services

- The Early Pregnancy Assessment Unit (EPAU) provided early scans and consultations for womens experiencing problems in pregnancy between 6 and 18 weeks gestation. This was based on Branstom Ward and was open Monday to Friday 7.30 am to 6pm. There were five scans available each day for staff to refer women with bleeding or concerns in early pregnancy. Out of these working hours womens would attend emergency departments, or leave a message in a non-urgent situation, for example a very small amount of vaginal bleeding.
- Community midwives were available 24 hours a day, seven days a week to facilitate home births.
- GPs could refer women directly to the gynaecology ward 24 hours a day by contacting the on call gynaecology doctor.
- The maternity assessment day unit was open 8am to 9.30pm seven days a week.
- A supervisor of midwives (SoM) was available 24 hours a day, seven days a week through an on-call rota. Women and staff had to call the labour ward at Pilgrim Boston to access the SoM on duty. This on-call system provided support to midwives and womens at all times. The hand held antenatal records included details of how to contact the on-call SoM. The LSA audit did question if

this was the best way to contact the on call SoM as there was a risk of labour ward midwives acting as a 'gatekeeper' to calling the SoM. The trust investigated the possibility of the switchboard being responsible for the on-call rota, but this was not possible due to financial constraints.

- Consultant obstetricians, gynaecologists and anaesthetists were either resident on the unit or on-call 24 hours a day, seven days a week.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards policy; however, this had no date of approval or date of review on it. The trust also had a consent for examination and treatment policy.

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- Training on consent, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards and learning disability was part of mandatory training for all staff. This had been completed by 88% of staff within women's and children's services. This did not meet the trust target of 95%.
- Staff were aware of their roles within the mental capacity act and how to cater for women's individual needs.
- Consent to care was obtained in line with national legislation and guidance, including the MCA.
- Within the termination of pregnancy clinic, as part of the care pathway women were given sufficient time to ask questions and to spend time with staff prior to giving consent to the procedure. During this time all options were sensitively discussed with the woman and where appropriate their partner. Women were offered a second consultation if they were not entirely certain about their decision to terminate their pregnancy.
- The trust's consent for examination and treatment policy supported making the women's best interests central to the process of obtaining consent. If a young person was under 18 and wished to consent to their own treatment, for example if they wished to undergo a termination of pregnancy, staff followed Gillick Competency and Fraser guidelines to assess whether the young person would have the maturity and intelligence to understand the risks and nature of treatments. Gillick competency and Fraser guidelines are used to help assess whether a child under the age of 18 has the maturity to make their own decisions and to understand the implications of those decisions. The young person would be given time to consider all the options.
- Secretarial staff monitored documentation completion rates and avoided delay in women's treatments.
- Staff members within the termination of pregnancy clinic were aware of the complications that could arise from using family members to interpret for women who did not speak English and were considering a termination of pregnancy. Where possible women were seen on their own with an interpreter.
- Women gave implied consent for their care and treatment, and this was clearly documented in their records. We observed staff asking for consent prior to undertaking care and treatment such as blood tests and physiological observations.

- Within the gynaecology outpatient service registered nurses received training on the application of informed consent. This was being shared trust wide with Pilgrim Hospital. We saw that staff discussed risks and complications and gave women the opportunity to ask questions before they asked the woman to sign their consent.

Are maternity and gynaecology services caring?

Good



We rated caring as good because:

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

However, we also found:

- The unit struggled to gain feedback from non-English speaking families.
- Women's' privacy was affected by the location of staffing handovers.

Compassionate care

- We observed ward areas, listened to focus groups of staff and spoke with individual staff who were involved in women's care. We saw good interactions and found that staff responded compassionately, treating people with kindness, dignity and respect.
- Staff were sensitive to the personal, cultural, social and religious needs of the individual women.
- We observed staff respecting the privacy and dignity of women by knocking on doors and waiting to be invited in to the room, or behind the curtains around the woman's bed space.
- Between July 2015 and June 2016 the trust's Maternity Friends and Family Test performance (% recommended)

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was generally similar to the England average in the four areas of maternity, which are antenatal care, postnatal ward, birth and postnatal community. Of the responses for the postnatal ward and community, 97% of women would recommend the care to friends and family.

- The response rates were not as high as the trust would have liked. With a hospital response rate of 2% compared with a national average of 22.9%. They thought this was because they utilised a free text service for feedback. Despite staff reassurance women and family members were reluctant to use the free text service to respond. This was due to the individual phone providers sending a message to say it may cost to respond. The trust were trying to address this with further information for women.
- Feedback was not always gained from the non-English speaking members of the public.
- The trust performed better than other trusts for two out of 16 questions in the CQC Maternity survey 2015, in all other areas it performed about the same. The two areas which were better than other trusts were: being given appropriate advice and support when the woman contacted a midwife of the hospital, and whether the woman felt the length of stay was appropriate.
- Within the ward areas, staff performed handover at the nurse's station in the centre of the ward. This meant that people walking past or using the bathrooms could hear medical and social circumstances being discussed. Managers and staff felt that there was no other option to achieve a handover of care. This was not a process that was trust wide. A woman we spoke with reported concern about confidentiality as she had heard details of other people's social circumstances discussed at handover. This was due to the close proximity of the bathroom to the staff desk.

Understanding and involvement of patients and those close to them

- A national champion in healthcare report highlighted that women felt they received individualised care. They said they felt assured that staff were around when they needed them.
- The women we spoke with told us they were well informed and involved in planning their care.
- One partner we spoke with felt included in care particularly because they were given the option to stay in the hospital overnight.

- We saw an example of a woman with severe complications receiving complex multi-professional care being involved in her care. She told us she felt safe and well informed throughout the birth of her babies.
- Women discharged home were provided with detailed information on the signs and symptoms that they should look for, and how to seek advice. We saw women following this advice and contacting the ward after discharge.
- Women and families who had suffered bereavement did not have a designated room on Bardney Ward (labour ward). Normal delivery rooms were used to care for these families. We observed staff speaking with a woman who returned to the hospital with her four day old baby. They understood the woman was worried and performed tests and contacted paediatric staff to speak to the woman referring her to the relevant area.
- We saw staff using language line to discuss discharge arrangements with a family for whom English was not their first language.

Emotional support

- We were told by a woman that she felt part of the family on Nettleham ward. Staff appreciated that she needed extra support, and she felt they spent more time supporting her. Despite a difficult delivery and having to stay in hospital longer, staff had supported her both physically and emotionally.
- Women we spoke with told us they were asked in pregnancy about their emotional and psychological wellbeing. This was reflected in the notes we looked at.
- Staff described how they took time to give emotional support to women who had experienced a miscarriage, termination for fetal abnormality, still birth or a neonatal death.

Are maternity and gynaecology services responsive?

Requires improvement



We rated responsive as requires improvement because:

- There was no designated midwife led unit; giving women the choice of a home from home environment.
- Sensitive patient groups were mixed within the gynae-oncology clinic and antenatal clinic.

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- Women attending for emergency gynaecology appointments waited for unpredictable lengths of time. The length of wait was not audited.
- The lack of a dedicated elective caesarean section operating teams meant that in the event of an emergency women's surgery could be delayed.
- Clinic areas for families to use following the breaking of bad news were central to clinic and only accessible via public waiting areas.
- The trust did not have specialist midwives to support vulnerable women, for example, teenage pregnancy, substance misuse, domestic abuse or the migrant population.
- The lack of dedicated waiting areas for families on Bardney Ward meant that families suffering a loss had to wait in the corridor. There was not a suitably quiet or secluded room, designated for a woman to deliver a still born baby.

However, we also found:

- The service had increased the number of trust wide specialist midwives. Some of these such as the bereavement midwife had not started.
- The trust had reintroduced birth preparation classes. A digital virtual tour would also be available.
- Women and families knew how to raise a concern and were treated compassionately when they did.

Service planning and delivery to meet the needs of local people

- The trust had recently employed specialist midwives to provide extra support to women and families with more complex needs. The posts were new and some staff were not in position. This included a bereavement midwife, a midwife with specialist safeguarding knowledge and a weight management/diabetes midwife. The safeguarding lead was able to support the staff in caring for families with extra social needs. Trust wide, this was approximately 193 known child in need and child protection cases at present. At present there was no infant feeding co-ordinator, although that was due to be addressed.
- Women were given a choice of where they wished to give birth in line with national guidance, which recommended both a choice in place of birth and a lead carer. This included the choice of a home birth or birth in a hospital supported by midwives, consultant obstetricians and anaesthetists.

- The service did not provide a designated midwifery led unit; although women who were deemed to be at low risk did receive midwifery led one-to-one care in labour within the consultant ward. Staff attempted to make a more homely environment, but the designated rooms were located next to theatres and without an en-suite toilet.
- Consultants and midwives ran combined clinics for women with endocrinology complications and weight management clinics.
- Antenatal weight management clinics were run in conjunction with the diabetes clinics.
- Midwives ran anti D and postnatal clinics within the community midwives area or clinic. Anti-D is a medicine used to prevent antibody formation in women who have a rhesus negative blood group and who have a rhesus positive baby. Anti-D is given to the mother to reduce the chances of antibodies being formed and any subsequent complications. This can lead to complications that may affect the baby after birth, or complications with a different pregnancy at a later stage should the woman become pregnant again.
- Nurse led termination of pregnancy clinics were run in clinic. Staff took care to keep termination and early pregnancy clinic separate.
- Colposcopies and hysteroscopies (a procedure to find out if there are abnormal cells on or in a woman's vagina or cervix, and a procedure used to examine the inside of the uterus) took place in a room off the ward. There was a consulting room with a couch where the women were consulted and procedures were performed. Separate recovery areas and waiting room were provided for women undergoing day case colposcopies.
- Antenatal care was provided in general practitioner (GP) surgeries, children's centres and at the maternity unit. The service offered specialist antenatal clinics including a multidisciplinary diabetic clinic and haematology clinics.
- The hospital had a dedicated screening co-ordinator; the service was supported by the antenatal clinic lead. Women requiring more invasive screening were referred to neighbouring tertiary clinics.
- Parent education classes had recently recommenced and were described as birth preparation classes. Since introduction these had become oversubscribed

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requiring more midwives to have time set aside to provide them. A digital tour of the unit was in production in view of the high demand for women to tour the unit.

- Women who were admitted for terminations of pregnancy were admitted directly to the gynaecology ward, although were not always allocated a single room. Staff attempted to provide single rooms, but due to bed capacity there were times when women undergoing a pregnancy loss or termination of pregnancy could be nursed alongside other women.
- The mixing of sensitive patient groups was an even greater problem within the gynaecology outpatients department. Due to lack of space and clinic size within the current gynaecology outpatient's clinic (Hemswell), every Tuesday the clinic moved across to the antenatal outpatients department. The limited space in Hemswell was additionally impacted by the presence of clinical neurophysiology department within the area. Three rooms within the gynaecology clinic were occupied by this service. Staff told us they tried to keep the women attending for gynae-oncology appointments in a different area from women awaiting ultrasound scans (USS). However, during our inspection women potentially losing their ability to have children were sitting opposite women holding pregnancy handheld notes awaiting USS. The waiting room and clinic areas also involved shared toilet facilities. During the clinic swap, women waiting for early pregnancy threatened miscarriage appointments waited alongside visible pregnant women.
- Women attending on the ward with emergency gynaecology symptoms would often have to wait for long periods

Access and flow

- Women requiring urgent gynaecology or early pregnancy care were seen on Branstons Ward. Due to the unpredictability of the service women would sometimes have to wait for long periods either due to the lack of available doctor or due to waiting for an USS. There were no dedicated same day emergency USS appointments. Staff monitored the waiting times during the visit and tried to ensure women were seen as soon as possible. The ward did not audit waiting times, but kept women informed at all times.
- Staff across the service used an electronic bed state to monitor bed vacancies and inductions of labour. Staff

told us that if work load was becoming unsafe then the system allowed staff to monitor if women could be diverted to Pilgrim Hospital. This was performed prior to escalation to silver command. There were episodes of both hospitals being closed.

- The elective caesarean section (CS) theatre list ran every morning, Monday to Friday. Routinely three cases a day were booked. The medical theatre team performing the operations were also responsible for emergency care on the labour suite. Staff told us, and we witnessed, that if the labour ward was busy then the elective operations would be delayed. Women who had not eaten or drunk prior to surgery could remain starved for up to 14 hours. In the event of delay, a policy was in place to assess all women's level of hydration and discuss drinking with the anaesthetists. Anaesthetic staff performed an audit of the time spent nil by mouth for elective section women..
- Between May 2016 and October 2015, the notes of 50 women were reviewed. Contrary to trust policy the average fasting time for food was 14.8 hours and for fluid 7.7 hours. During that time 14 women (28%) had their surgery delayed due to commitments on labour ward. Actions were suggested to encourage women to drink 30 millilitres per hour prior to surgery. Women we spoke to were aware there would be the possibility of a delay in their caesarean. It was rare for cases to be delayed to the next day, but it was known to happen. Staff told us that in the event of delayed treatment, incident forms were completed, but that the incidences of caesareans being delayed until the next day were not audited.
- Between April 2016 and May 2016 between 84% and 88% of women attended for antenatal services within 12 weeks of their pregnancy. This was close to the trust target of 90%.
- Elective gynaecology surgery was mainly carried out within the day case theatre.
- Trust wide, medical and surgical terminations were offered to women up to 12 weeks and six days. Women beyond that gestation were referred to an alternative independent termination service. Women attending for an appointment to discuss a termination of pregnancy were offered the procedure within five working days of the decision to proceed. Surgical terminations of pregnancy were not offered at Lincoln County Hospital. Women choosing this method attended Louth Hospital.

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- Trust wide between January 2016 and June 2016, on average 94% of women waiting for gynae-oncology appointment were seen within two weeks, which equated to 966 women. This was better than the trust target of 93%.
- The trust did not collect data relating to the percentage of women seen by a midwife within 30 minutes and if necessary a consultant within 60 minutes during labour. However, staff told us all women were seen immediately on transfer to Bardney Ward.
- The gynaecology ward monitored the occasions when women from other specialities (outliers) were cared for on Branston Ward. This did not happen often, and staff repatriated patients as soon as possible to the appropriate ward. During our three-day visit, there were no outliers on the gynaecology ward.

Meeting people's individual needs

- A named midwife was included in the women's handheld records for care during the antenatal and postnatal periods. We saw evidence of staff using language line and face-to-face interpreters throughout pregnancy, delivery and the postnatal period. Many leaflets throughout the unit were in Polish, Russian and Latvian, as these were commonly spoken languages.
- Nurses on Branston Ward spoke about working closely with families whose members had learning disabilities. They made arrangements to adapt care and include the carer to reduce anxiety, for example, pretending to perform a blood pressure reading on the carer first, visiting at home and carers staying with women.
- All women admitted over the age of 75 had a confusion score documented within the care plans. The confusion assessment highlighted those at increased risk whilst in a new environment.
- The rooms available in clinic for breaking bad news were centrally placed and across the waiting room from the USS department. Women and families receiving bad news had to walk through the waiting room both to enter and to leave the room. This could be distressing for all concerned.
- A well-equipped bereavement room was available on Nettleham Ward for families with sick babies or who have suffered loss. However, during delivery of their baby, women would be in a room on labour ward (Bardney) and then move back to the bereavement room on Nettleham Ward. There wasn't a discreet area on Bardney Ward for families to wait when not in the labour room.
- There was no waiting area for relatives on Bardney Ward. This meant that all relatives, including those in stressful situations had to sit on chairs in the corridor.
- There had been a recent employment of a specialist bereavement midwife. Until recently all staff were responsible for ensuring bereavement facilities were adequate and literature up to date for supporting families. This included facilities for early pregnancy loss or termination of pregnancy. Staff told us the increased support would be beneficial to both families and staff.
- The multi faith hospital chaplains were available to provide emotional support to women and those important to them.
- The lack of a midwife led unit, either stand alone or alongside within the area reduced the choices offered to women. The birthing numbers had dropped from the previous year. Although no formal analysis of these figures had occurred staff felt the lack of MLU was a factor in women's decision on where to birth.
- Partners were invited to stay overnight on Nettleham Ward if they wished. At present there were washing facilities, but no shower facilities for partners that did stay overnight.
- The new wet room on Nettleham Ward and Bardney were suitable for wheelchair access and most labour rooms were large enough for access. Two of the rooms would not be suitable for use.
- Not all labour rooms had en-suite toilets, which would mean a woman in labour, would have to either use a commode in her labour room, or dress and move across the corridor to use the toilet. This could be undignified, uncomfortable or disruptive to the relaxation for women.
- Staff reported that although the mental health liaison team had improved support, support for women with complex social or mental health needs was quite limited. During acute crisis the mental health team were supportive, but did not have capacity for longer term support.
- The trust has not been able to fully implement recommendations from NHS England Saving babies lives report (2016). Due to the lack of local authority public health funding there was not a smoking cessation midwife. Also, the current limited availability of USS

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appointments meant that current guidance of increased serial USS assessments or USS surveillance could not be followed. The trust told us they had plans to implement a staged approach to implementing the guidance.

- Following a termination of pregnancy, women could access external counselling support. Staff also spoke of the support offered to staff and women from the Mental Health Liaison Team. These were based at each hospital and contactable 8am to 10pm seven days a week.
- The trust only offered surgical termination of pregnancy at Louth hospital. Staff felt this restricted women's choice. Data was not collected on those who changed their preferred method of abortion, or went back to the GP to be referred to a local private clinic due to the distance and lack of transport.
- Learning disability and dementia nurses were available to support staff in caring for women with complex needs.
- Gynaecology staff received dementia awareness training as part of their mandatory training.

Learning from complaints and concerns

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

Are maternity and gynaecology services well-led?

Good



We rated well-led as good because:

- The women's and children's business unit strategy was driven by quality and safety. Short-term changes were performed to improve services for women within the current constraints.
- All levels of the governance framework with exception of the current maternity dashboard functioned effectively and were embedded into every day practice. This included the changes that had occurred in the last two years.
- A strong business unit team had increased the visibility of the women's and children's business unit in the last 18 months.
- An increase in the number of matrons had strengthened the clinical supervision of staff and improved the leadership at local levels and trust wide.
- Teamwork throughout the hospital was apparent and something all staff were very proud of.

However, we also found:

- The uncertainty of the future model of maternity services was impacting on the estates and facilities provided
- Data collection was not as robust due to the lack of specific maternity IT systems, although this was underway.

Vision and strategy for this service

- United Lincolnshire Hospitals NHS Trust has been developing a five year strategy since 2014 which aimed to develop a portfolio of high quality services delivering excellent care.
- They were looking to develop new and innovative models of care, which will fully integrate partnership care pathways across primary and acute health. A multi-agency approach was used to develop care systems to be delivered through the five-year place

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based Sustainability Transformation Plan (STP). At the time of our inspection there were no clear plans of how that service will look, or where women's and children's services would be provided.

- The current vision for the service had been overshadowed by the uncertainty of the future plans. However, staff kept improving quality of care for women at the centre of everything they did.
- Women's and children's business unit had developed strategic plans to improve the physical environment of the maternity block. These have included short-term cost effective alterations to improve conditions, but will not provide the midwife led facilities required to improve compliance in keeping with the Maternity Review 2016.
- Staff within the trust were aware that there were many changes in the future, but could not articulate what these may be. They expressed that the women's and children's service would possibly be united across both sites, but could not visualise the service.
- The Women's and Children's business unit leads met regularly and played an active role in the development and monitoring of the sustainability and transformation plan.

Governance, risk management and quality measurement

- A well-defined governance and risk framework was in place and part of everyday practice. The maternity risk management strategy outlined the roles and responsibilities for all staff across maternity services. It gave clear guidance to support safe and effective care, and ensure that risk management in maternity services was consistent with trust risk management policies.
- In the past two years, the governance arrangements and structure had been strengthened significantly. This included monthly multidisciplinary maternity governance meetings and quarterly trust wide meetings. We were told by staff that there was an improved trust wide awareness of governance issues. Dedicated risk management staff had been appointed in all areas to work proactively with wards, audit leads, matrons and policy group to recognise and raise concerns.
- Weekly multidisciplinary unit incident meetings occurred (IR2 meetings) to discuss reported incidents. This included good practice and areas for improvement. The notes of this meeting were emailed to all staff to be aware of recommended actions and trends in incidents.
- The increased awareness of risk and incidents had made staff more aware of the incident review process. Some felt this could still feel punitive, but could not give examples why, however, they appreciated the fact that good practice was also recognised.
- Quality and performance data was monitored through trust wide governance meetings that fed into the business unit performance review. The maternity dashboard was currently under review, and data provided by the trust did not include a red, amber, green flagging system. The lack of electronic maternity data management systems meant that data was collected manually, and not always consistent. The introduction of a maternity IT system was underway, and staff told us data collection would become more robust.
- The local risk register assisted the corporate governance group to identify and understand risks. There were 17 risks identified for maternity and gynaecology. Of the risks, nine were classified as extreme or high, six were identified as moderate risk, and two were classified as a low risk. We reviewed information which indicated the description of the risk and subsequent action taken, plus the outcome where known. For example, changes had been made to theatre two on Bardney Ward and the risk of splash contamination assessed if the theatre was used for a second emergency. We found there was clear alignment of what staff had on their worry list with what was on the risk register.
- A systematic programme of clinical and internal audit had been developed; however, demonstration of completion and presentation dates was not always clear. Many audits were described as ongoing with little evidence of actions taken from them. The governance team recognised this, and seconded an audit midwife. Part of her role was to strengthen the process and improve feedback on the ongoing audits.
- The assessment process for termination of pregnancy legally requires that two doctors agree that at least one and the same legal grounds for termination of pregnancy are met and sign a form to indicate their agreement (HSA1 Form). We looked at two termination of pregnancy records and found that both forms included two signatures and the reason for the termination. Completion of HSA1 (grounds for carrying

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out an abortion) and HSA4 (abortion notification) forms were completed by two doctors who followed guidance and submitted the forms to the Department of Health as required.

- The government had commissioned an independent investigation into maternity and neonatal services at Morecambe Bay (the Kirk up report, 2015), to examine concerns raised by the occurrence of serious incidents. Good practice would be to benchmark against these recommendations. Data provided by the trust demonstrated the service monitored compliance with key elements of the Kirkup report, such as improving duty of candour and feeding back to families.

Leadership of service

- The women's and children's business unit demonstrated a clear leadership structure which included strong clinical engagement. Consultant staff told us there was a proactive approach to decision making, such as the developing of the consultant 'hot week' role. The leads were aware their visual presence was not always apparent in all areas, particularly trust wide. This appeared to be mitigated by the employment of strong matrons who could represent the head of midwifery and nursing and have more time to communicate with staff. The planned employment of a deputy head of midwifery would further support this. Despite this reduced visibility staff all felt that the leadership of the service was strong and driven, with women and children at the heart of everything the team did.
- The change in leadership style over the previous two years had been a challenge for ward leaders. Staff described the new head of midwifery and nursing as a 'driving force' for maternity and gynaecology. The 'confirm and challenge' session held monthly with the head of midwifery and nursing caused a change in management style. Ward leaders at both sites told us they now felt confident in the management of their wards and were always aware of staffing, sickness, appraisals, training and budgets. Trust wide matrons told us the new proactive style had given them the confidence to move the service forward, and felt it was respected more by the trust as a whole. We received mixed views on how approachable staff found current leaders.

- The relationship between the clinical director and the three members of the women's and children's business unit senior team was described as open and very much a partnership. Womens' and children's services were the focus of the trust long term plans.
- Staff described local leadership within areas as varied, some felt ward leaders were strong and supportive, whilst others less visible. Staff did however; describe a good relationship with matrons, and an assurance that complaints and concerns would be addressed. The strengthening of this tier had appeared to increase clinical support throughout the trust.
- All midwives had a named Supervisor of Midwives and had received their annual review.
- Most staff felt that new ideas were appreciated and considered such as the optimising normal birth within labour ward and normal birth group, and the replacement delivery trollies.
- Staff within gynaecology felt that the profile of the service had been elevated in the last two years by the head of midwifery. They appreciated the employment of a matron overseeing both sites and the ward leader was very proactive for the staff and women within the service.

Culture within the service

- We observed strong team working, with medical staff and midwives working cooperatively and with respect for each other's roles. All staff spoke positively and were proud of the quality of care they delivered, but felt that time to care was limited. In most areas, staff did not feel that the two hospitals worked together well and the services operated separately.
- Staff in both hospitals had worked hard during some difficult financial times. They felt that managers appreciated the hard work, but they did not always feel included in long term changes. Staff told us ward meetings were rare, however we saw minutes of ward meetings that demonstrated they did occur, although sporadically and attendance was limited.
- The culture within the hospital did encourage candour with an open and honest culture. This was demonstrated in the sharing of incidents and learning both via emails and the W&CBU newsletter. Staff were also directed to the trust policy as well as external

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websites for further examples of duty of candour. We saw in the review of notes debriefs with families after emergency procedures. A proforma for this was included in the intrapartum booklet.

- Junior doctors told us they felt well supported by consultants throughout the maternity and gynaecology service.
- Senior consultants described supporting colleagues whose practice was not considered in line with guidelines.

Public engagement

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







Staff engagement

- Most staff told us they had confidence that they were informed of significant changes. The wait for the outcome of the STP project appeared to overshadow all other short term plans. A few midwives expressed staff development opportunities were not advertised enough, and that there were very few development roles. Several new posts had been created within risk, bereavement, infant feeding and IT.
- The unit managers had recently introduced a newsletter that was emailed to all staff and had copies in the staff lounges. This included a range of trust wide information on changes.
- Midwives with a specialist interest in normality in labour, planned and led free study days for staff. This included external speakers providing staff to learn from other units and use the information to drive change

Improvement and sustainability

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

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

Information about the service

United Lincolnshire Hospitals NHS Trust provides care for children and young people at Lincoln County Hospital and Pilgrim Hospital Boston. Lincoln County Hospital provides paediatric services for children from 0 to 16 years of age including day case and emergency services.

There are 24 paediatric inpatient beds on Rainforest Ward, an eight bedded paediatric day case ward, Safari Ward and 15 level two neonatal unit cots on Nocton Ward. At the time of our inspection 19 paediatric beds and 10 neonatal cots were in use. The paediatric day case ward also caters for children requiring blood tests and those requiring a pre assessment prior to being admitted to hospital.

The neonatal unit was in a temporary location whilst refurbishment work was taking place.

There were 513 admissions to the neonatal unit between September 2015 and August 2016.

There were 3939 admissions between April 2015 and March 2016. Of these 98.7% were emergency admissions, 0.6% were day case admissions and 0.5% were planned surgical admissions.

During our inspection we visited Rainforest Ward, Safari Ward, Nocton Ward, paediatric and adult out patients department, radiology and theatres. We spoke with 19 staff, 12 relatives and five patients. Before our inspection; we reviewed performance information from, and about the trust.

Summary of findings

We rated this service as good because:

- There was a good understanding of the incident reporting system with most incidents reported being of the no harm to low harm category. The service had not reported any never events in the 12 months prior to the inspection.
- There were good infection prevention and control measures within the service and this was reflected in the zero cases of healthcare acquired infections.
- The use of the paediatric early warning score (PEWS) and neonatal early warning score (NEWS) was embedded within the service and aided timely recognition of the deteriorating patient.
- The service delivered care according to local and national policies which were evidence based, and also contributed to national audits to benchmark care against other providers.
- We observed many positive examples of compassionate and dignified care being provided to all patients. Feedback from parents, carers and the children themselves was complimentary about the care they had received and felt the level of information provided was adequate. They were also complimentary about the involvement of siblings in the patient experience and how staff extended the compassionate care to them.
- The service was responsive and met the needs of the children and young people accessing the service. The

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hospital had engaged with local parent groups about service planning and delivery and also provided facilities for parents to stay with their child whilst admitted.

- The service was well-led at local ward/unit level and staff told us and we found the leadership above this level was also good.

However:

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

Are services for children and young people safe?

Requires improvement



We rated safe as requires improvement because:

- Audit information provided by the trust showed there were still areas for improvement in the management of sepsis.
- There was no abduction policy available for any of the inpatient areas of the service.
- Safeguarding level three training did not meet intercollegiate guidance or the trusts own target for compliance.
- Nurse staffing on the children's ward did not meet the Royal College of Nursing standards. There was not a band six nurse allocated to each shift or a nurse qualified in advanced paediatric life support (APLS) or European paediatric life support (EPLS).
- Medical staffing did not meet the Facing the Future standards set by the Royal College of Paediatrics and Child Health (RCPCH). However there was a known national recruitment issue in this area.
- There was no ligature risk assessment completed for either of the children's wards.

However:

- Nurse staffing on the neonatal unit was in line with the British Association of Perinatal Medicine (BAPM) standards.
- Staff demonstrated good knowledge and understanding in relation to incident reporting and learning from incidents.
- All areas inspected were visibly clean and clutter free.
- Staff used paediatric early warning scores (PEWS) and neonatal early warning scores (NEWS) to appropriately identify a deteriorating patient.

Incidents

- The trust monitored safety through a ward health check reporting tool. We reviewed the results for September 2016 which showed there were amber ratings for some mandatory training elements and appraisals for the paediatric wards and neonatal unit.

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- Between August 2015 and July 2016 the trust reported no Never Events and no serious incidents for children's services. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers
- From July 2015 to July 2016 there were 377 incidents reported for the children and young people's service trust wide. Of these, 226 incidents were reported by the children's service at Lincoln County Hospital, the majority of which (197 incidents) were classified as no harm. There were three moderate incidents and 26 low harm incidents.
- Staff told us they were confident in raising incidents and received feedback in the staff newsletter or the monthly staff meetings, which we saw minutes of. We saw evidence of shared learning between the neonatal units of this hospital and Pilgrim Hospital.
- Staff demonstrated a thorough awareness of the Duty of Candour. They told us they applied the principles of Duty of Candour to all incidents and complaints. Staff were comfortable being open and honest with parents and parents appreciated the openness and honesty. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- We saw evidence of perinatal (the period immediately pre and post birth) mortality and morbidity meetings which demonstrated on going learning for future incidents. Mortality and morbidity meetings give health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning alerts?

Safety Thermometer

- Data from the Patient Safety Thermometer showed that there were no pressure ulcers, falls with harm or catheter urinary tract infections between July 2015 and July 2016. The Patient Safety Thermometer is a local improvement tool for measuring, monitoring and

analysing patient harms and harm free care. It focuses on four avoidable harms; pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).

Cleanliness, infection control and hygiene

- In the Care Quality Commission (CQC) children's survey 2014 the trust scored about the same as other trusts for the question 'How clean do you think the hospital room or ward was that your child was in?'
- The hospital used a software tool to audit ward cleanliness. The tool gave a red, amber or green score to each area. The most recent average scores (September 2016) were amber (92.3%) for Safari Ward, red (78.6%) for Rainforest Ward and amber (92.3%) for Nocton Ward.
- All areas we visited appeared visibly clean and free from clutter. Staff were bare below the elbow and used personal protective equipment such as gloves and aprons to carry out procedures and personal care activities.
- We saw the most recent infection prevention compliance assessment tool for safari ward dated September 2016. There were nine red rated areas, for example, 'Are all furnishings and fittings clean and in a good state of repair?' The assessment tool did not identify remedial action.
- Between January 2016 and June 2016 no cases of MRSA bacteraemia or Clostridium difficile (C. difficile). MRSA and C. difficile are infections capable of causing harm to patients. MRSA is a type of bacterial infection and is resistant to some widely used antibiotics. C. difficile is a bacterium affecting the digestive system; it often affects people who have been given antibiotics.
- We reviewed the monthly hand hygiene audits for rainforest and safari wards between March 2016 and July 2016. All showed 100% compliance in line with the trust target. Hand hygiene audits for Nocton Ward between March and June 2016 did not achieve the trust target of 100%.
- The infection prevention and control guidelines contained information on cannula insertion and management. The hospital used the visual infusion phlebitis (VIP) score. A cannula is a thin tube inserted into a vein or body cavity to administer medication, drain off fluid, or insert a surgical instrument and the VIP score enables early recognition of infection around the cannula and its removal to prevent further deterioration.

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- Legionella flushing records for September 2016 and until inspection showed 100% compliance for all paediatric ward areas.
- 'I am clean' stickers were used to indicate that equipment had been cleaned and was ready for use.
- All the toys in the play areas were wipeable and wipes were available to clean the toys.
- Cleansing wipes and personal protective equipment was not immediately available in the consultation rooms in the outpatient clinics and waste bins were not compliant with health technical memorandum (HTM) 83 as they were not enclosed and foot operated which are requirements under the larger waste management guidance document HTM 07-01 safe management of healthcare waste. The management and disposal of sharps was completed in accordance with trust policy.

Environment and equipment

- The trust scored about the same as other trust for the question 'Did the ward where your child stayed have appropriate equipment or adaptations for your child?'
- At our last inspection we identified that there were insufficient infusion pumps and heart monitors. The trust had increased the number of infusion pumps as well as the overall management of equipment. Staff told us they always had access to equipment when needed.
- The paediatric and neonatal risk registers both highlighted risks around equipment. For example, old equipment such as some infusion pumps, some incubators and ventilators. These items had been placed on a replacement plan. Clinical engineering department had oversight of this plan.
- Responsibility for the maintenance of equipment was clearly described in the trust policy for the management of medical equipment.
- Medical device maintenance was managed by a computerised system; jobs were red, amber or green rated in order of urgency. In addition a blue rating had been introduced to indicate immediate attention was required. The system also tracked equipment and produced live information on where equipment was located.
- Medical device engineers told us there was enough equipment. All items identified on the paediatric and neonatal risk register had been risk assessed and prioritised for replacement.
- Safety alerts relating to medical devices were received by the medical device safety officers who facilitated any action required. An example given was of a recent safety alert: Reducing the risk of oxygen tubing being connected to air flowmeters.
- We checked four pieces of equipment, they were all labelled to confirm they had been serviced in the past twelve months and gave the date of the next scheduled service
- We saw a dedicated paediatric waiting area in nuclear medicine.
- The play areas on the paediatric wards were well equipped with toys and videos to suit different ages.
- Prams and pushchairs were available for parents to use.
- There was a children's outpatient clinic but children were also seen in other clinics. Although the children's outpatient clinic was appropriately equipped, the other clinics did not have specific children's waiting areas. Smaller children attending the general outpatient clinics could wait in the children's outpatient clinic if preferred and would be called for their appointment from there.
- Children were recovered following surgery in a dedicated recovery area for children.
- We checked four resuscitation trolleys in the outpatient area. The trolley in the radiology area had not been checked in line with trust policy and was stored in a room used for isolating infected patients. We found three items of equipment out of their sterile wrappings and five items of equipment without visible expiry dates. This meant the trolley was not read for use in the event of an emergency.
- We checked a resuscitation trolley in the physiotherapy department where children attended for appointments. On initial review, there was no paediatric equipment provided for this department. We escalated this during our inspection and this was rectified immediately.
- We found 15 out of date blood test bottles in the outpatient department. This was not good practice as inaccurate results could be received if they were used to collect patients' blood.
- In the medical physics camera room parents were able to stay with children due to the availability of equipment which protected them from radiation.

Medicines

- The resuscitation trolley in the outpatient department did not hold paediatric emergency medicines. This

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meant if a paediatric arrest occurred, emergency medicines would not be available to treat the child. We raised this during the inspection and the trust addressed this straight away.

- Medicine fridges were checked daily and documented; staff knew what action to take if they found the temperature to be out of the recommended range.
- We reviewed nine sets of medication records. All were legible, up to date and showed medical review, VTE assessment, and medicines reconciliation where relevant had taken place. One set did not have a documented recording of the child's weight. Medicine reconciliation is the process of creating the most accurate list possible of all medications a patient is taking.
- Allergies were clearly recorded on the front of the prescription chart. Patients with drug allergies wore red wrist. This minimised the risk of the patient receiving medications which they were allergic to.
- A paediatric pharmacist visited the children's wards daily and reviewed all medication charts.
- We requested antimicrobial audits for the children and young people's service however, the information was not provided as the hospital did not complete antimicrobial audits for this service.
- We requested data for missed doses audits for the children and young people's service however the information was not provided as the hospital did not complete missed dose audits for this service.
- The hospital did not have a policy to support young people managing their own medication.
- We saw the secure handling of medication audits for the paediatric day case and inpatient wards. The inpatient ward scored 90% and a plan was being developed to address the safe storage of medicines. The day case ward scored 80% and an action plan was being developed to address safe storage of medicines and access to medicines.

Records

- Each child had one set of paper records which were used by all members of the multidisciplinary team.
- Risk assessments were completed and reviewed as necessary such as infection prevention and control, bed rail assessments and pressure sore assessments.
- Patient records were stored in notes trolleys which were not locked, however they were located in areas which was always monitored by staff.

- There were systems in place to identify on a child's record if there was a particular issue such as safeguarding or diabetes.
- Information was shared with GP's, school nurses and health visitors through an electronic system used by the trust.
- We observed confidential patient notes left unattended in the outpatient corridor which meant they were not stored securely as per the trusts information governance policy.
- There was a flag system available on the computer admission system at the hospital which identified children who were at risk and for 'looked after children' (LAC). The medical records also contained details around the specific risks of the child and any action plans which were in place.

Safeguarding

- The Chief Nurse was accountable for safeguarding within the trust supported by named leads.
- The trust set a mandatory target of 95% for completion of safeguarding training.
- All staff working with children and young people should be trained to level three safeguarding. The trust reported that at September 2016 three areas were not compliant with this standard. The paediatric ward (74%), paediatric clinic (67%) and neonatal unit (82%).
- The trust wide policy for safeguarding children dated September 2015 contained information and guidance on female genital mutilation (FGM) and child sexual exploitation. Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.
- Between April and October 2016 the trust had reported eight cases of female genital mutilation, however six were type four which included piercing. This meant that staff were aware of the safeguarding policy and the reporting procedures for FGM.
- Staff described the action they would take if they identified a safeguarding issue; this was in line with the trust policy.
- Consultant paediatricians held monthly safeguarding peer discussions during which they presented difficult cases. This also facilitated experiential learning for trainees.
- Safeguarding alerts could be viewed on the electronic patient information system. This enabled sharing of information particularly with community nursing teams.

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- The trust did not have a policy in place for non-accidental injury. Non accidental injury is any abuse purposefully inflicted on a person it can be physical or emotional.
- There was no abduction policy for staff in the children and young people's service to follow. Staff members were however, able to provide details of steps they would take in the event of a child or young person going missing in their ward areas.
- The trust were not able to break down the number of safeguarding referrals just for children's services. There were 94 safeguarding referrals made by staff in Patient's and Children's business unit between August 2015 and September 2016.
- Children did not express any reservations about sharing their worries with staff and that staff were patient and took time to listen.
- There was a room available on Safari Ward for forensic examinations of children suspected of abuse. If there was a case of suspected child sexual abuse, the child would be transferred over to another location where dedicated facilities were available.
- We could not be assured that staff followed the DNA policy for the children's outpatient department, Between November 2015 and October 2016 there were 2003 children who did not attend their appointment in the paediatric outpatient clinic. Of these 1116 were given, and attended, a follow up appointment. No details were provided for the other 887 children who did not attend their appointment. This meant we were not assured that these children had been followed up in accordance with the trusts policy.

Mandatory training

- All staff completed an induction programme; the mandatory elements were repeated once a year.
- Mandatory training included fire safety, infection control, equality and diversity and human rights, information governance, health and safety, slips trips and falls, moving and handling, risk awareness and fraud awareness. The trust set a mandatory target of 95% for completion of mandatory training. Completion rates for Rainforest and Safari wards were 95% which was in line with the trusts target.
- Information supplied by the trust showed the neonatal service had an 83% overall compliance rate with mandatory training which meant they had not achieved the trusts own target of 95%.
- A sepsis electronic learning programme was being rolled out to all staff at the time of our inspection, we asked for numbers of staff that had completed this training but this was not provided for this hospital.

Assessing and responding to patient risk

- The trust had guidelines for the rapid recognition and assessment of the sick child. The guidance had been reviewed in September 2016. The guidance was for health professionals in the hospital setting and was audited annually.
- Patient record templates contained a comprehensive selection of risk assessments plus prompts, hints and tips for staff based on best practice guidance. For example the, the Glamorgan score for paediatric pressure ulcer risk assessment and a modified paediatric Glasgow coma scale.
- A sepsis bundle was introduced into the service in 2014 and information provided by the trust showed that this was embedded and had been working well. However, audit information provided by the trust showed there were still areas for improvement in the management of sepsis. Of the 10 patients included in the audit, none of them received antibiotics within the recommended hour and none of them had oxygen therapy administered. One patient out of the 10 included in this audit had a screening proforma completed. Findings did however highlight that when patients were given antibiotics, these were in accordance with trust policy. Sepsis is a life threatening condition that arises when the body's response to infection injures its own tissues and organs.
- A separate chart was used to assess paediatric sepsis following the UK Sepsis Trust guidelines, Sepsis Six. Use of the sepsis six guidance has been shown to be associated with significant mortality reductions when applied within the first hour. The six steps identified the need for rapid escalation and treatment when sepsis is suspected.
- A paediatric early warning score (PEWS) was included in the patient records with guidance for staff on how often to complete the observations and when to escalate care to medical review. Early warning scores have been

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developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.

- We observed staff completing routine observations and PEWS. Staff described to us the action they would take in the event of the PEWS being out of normal range.
- A checklist had been formulated for staff to complete to assess the risk that children admitted with self-harm posed. These individuals posed and identify the level of support they may require for example one to one observation.
- Paediatric patient day case surgery records covered discharge planning including advice to give to the parents of the child on what to do if the child became unwell 24 – 48hrs post-surgery.
- If children had not fully recovered from day surgery procedures by the time the ward closed for the day, they were transferred and admitted to Rainforest Ward.
- The patient anaesthetic and surgical record incorporated the World health organisation (WHO) Safer Surgery Checklist. We observed staff thoroughly completing the checklist in the operating theatre during a patient's procedure.
- The WHO Safer Surgery Checklist monthly audit, March 2015 to February 2016, for Lincoln County Hospital was 93% which did not meet the trust target of 100%.
- The trust told us there were no ligature risks in the areas we inspected but were unable to provide us with a documented risk assessment.
- There was a transfer policy in place for children or young people who required a high level of care that could be provided at the hospital. For children that required transfer to a different hospital, staff from the ward would accompany the child if they were not ventilated (a tube inserted into the trachea to provide oxygen to the lungs). If the child was ventilated prior to transfer, the retrieval team would transfer the child themselves. For neonates requiring transfer to a different hospital, there was a transport team who would be responsible for collecting the infant and transferring them to the receiving hospital.
- Staff in the medical physics department told us that one of the two CT scanners used slightly lower doses for scanning patients. The same staff told us that paediatric patients would be scanned on the lower dose scanner whenever possible.

Nursing staffing

- As at June 2016, Lincoln County Hospital reported a vacancy rate of 17 % in children's services; this was based on 16.85 whole time equivalent vacancies.
- As at June 2016, Lincoln County Hospital reported a turnover rate (rate of staff leaving the trust) of 0.2 % in children's services.
- As at June 2016, Lincoln County Hospital reported a sickness rate of 0.1% in children's services.
- From April 2015 and March 2016, Lincoln County Hospital reported a bank and agency usage rate of 2.7% in children's services.
- Royal College of Nursing (RCN), Paediatric Nurse Standards recommend a ratio of one nurse to 4 patients over the age of two during the day and at night and a ratio of one nurse to three patients under two years of age day and night. A ratio of one nurse to two patients is recommended for patients requiring high dependency care. The guidance also recommended at least one band six nurse on every shift.
- The paediatric risk register dated August 2016 highlighted as a red risk that ward establishments did not enable the service to meet the RCN standards on Rainforest Ward, Safari Ward, neonatal unit and children's clinics.
- International nursing staff were being recruited however the process for them to register with the professional body was comprehensive which meant the nurses had to commence work as an unregistered member of staff and progress to a registered post once competencies were completed and notification of registration received.
- A senior nurse on call rota was not in place, staff told us they would ring colleagues at home if they needed any advice. Managers told us they were considering implementing a senior nurse rota but it was challenging due to the low number of senior nurses and therefore difficult to cover a 24 hour rota.
- Band four nursery nurses had completed additional competencies such as the paediatric early warning score, so they could be utilised to support nursing staff by taking on additional responsibilities.
- Nurse staffing on the neonatal unit was based on the British Association of Perinatal Medicine (BAPM) and RCN guidance. On each shift there were three registered staff and one unregistered member of staff, with at least

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one registered member of staff qualified in neonatal nursing (qualified in speciality). These standards were applied to both day and night shifts and the rotas we reviewed reflected this.

Medical staffing

- As at June 2016, Lincoln County Hospital reported a vacancy rate of 9.3 % in children's services; this was based on 2.6 whole time equivalent vacancies.
- As at June 2016, Lincoln County Hospital reported a sickness rate of 2.5 % in children's services.
- From April 2015 to March 2016, Lincoln County Hospital reported a bank and locum usage rate of 12.6% in children's services.
- The paediatric risk register dated August 2016 highlighted as an amber risk insufficient medical staff and the inability to staff medical rotas fully across the paediatric and neonatal services.
- The proportion of consultants reported to be working at the site was lower than the England average.
- The proportion of junior doctors reported to be working at the site was higher than the England average.
- A paediatric consultant was on call 24/7 and able to attend the hospital in 30 minutes if required.
- The Royal College for Paediatric and Child Health (RCPCH) facing the future: standards for acute general paediatric services were not completely met at the hospital. There were eight consultant paediatricians working at this hospital. They had implemented the consultant of the week model however the presence of the consultant on site was from 9am to 5.30pm, Monday to Friday, and 8.30am to 1pm on Saturday and Sunday.
- The Trust had introduced the Hot Week duties for consultants. Each week two consultants would undertake this role (one for paediatrics and one for neonatal service)

Major incident awareness and training

- The service had their own winter management plan which included business continuity plans to cover increase in attendance for winter related illnesses in children, such as bronchiolitis. Staff did however tell us they would need to review this policy, but had previously worked well when implemented.
- When asked about major incident policies and training for this, staff were unaware of this and had not received any specific training.

- Staff had attended fire training as part of their mandatory training; however they had not completed any practical training for ward evacuations. Staff told us they would know what to do in the event of a fire as the classroom training was very detailed.

Are services for children and young people effective?

Good



We rated effective as good because:

- The service contributed towards national audits to benchmark the care given against other services nationally.
- The service were following evidence based policies and guidance. A selection of policies reviewed were all in date.
- There was a supportive training programme for medical trainees within this service.
- Appraisal rates for staff on both paediatric wards were above the trust target of 95%.

Evidence-based care and treatment

- National guidance and royal college guidelines were evident throughout policies and procedures. For example, the trust wide patient's and children's annual business plan referred to the Royal College for Paediatric and Child Health (RCPCH) 2011, Facing the future, RCP 2007 The right person in the right setting – first time and RCN paediatric nurse standards. The paediatric day surgery care plan was based on Royal College of Anaesthetists and Royal College of Nursing guidance.
- National Institute of health and Care Excellence (NICE) clinical guidelines were implemented throughout the patient care pathway for example jaundice guidance.
- We observed a child in the operating theatre suite before, during and after a surgical procedure. All checks and procedures were carried out in line with the Association for Perioperative Practice recommendations.
- A comprehensive audit programme was in place. We saw 11 audit topics had been identified for the period March to August 2016. Results from previous audits were reported to the clinical governance meeting. Actions

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were clearly identified. Local audit topics included paediatric early warning scores (PEWS) observation audit, neonatal unit observation/prescription checklist and bronchiolitis audit to see if compliant with NICE guidance. Staff told us they took part in audit and shared results at team meetings.

- Consultant paediatricians also held monthly audit meetings when the results of audit would be presented. Topics included NICE clinical guidance audits such as febrile neutropenia (signs of infection in a patient with low levels of white blood cells), national audits such as the diabetes audit and local audits. This enabled sharing of learning that had emerged as a result of the audit.
- The neonatal unit had achieved level one of the UNICEF baby friendly initiative which was aimed at supporting breast feeding and improving parent-infant relationships by working with public services to improve standards of care.
- The neonatal unit also participated in the BLISS baby charter, which was a practical guide for hospitals to enable them to provide the best possible family-centred care for premature and sick babies.
- Patient information leaflets were available for children and young people which were all evidence-based and within their review dates.

Pain relief

- Pain assessment were included in the observation chart.
- We observed anticipatory pain relief being administered in the operating theatre. Pain was assessed in the recovery room using the face, legs, activity, cry and consolability (FLACC) scale for assessing a child's pain, post-surgery. Morphine was administered according to the hospital paediatric morphine protocol.
- Staff on the wards used a numerical pain score of zero to three for older children and a faces chart which corresponds with a numerical pain score for younger children.
- We observed ward staff assessing pain following surgery and administering pain relief as prescribed.
- Parents and children we spoke with told us that pain relief was administered promptly when required.

Nutrition and hydration

- All children received an initial review of their dietary requirements on admission. If there were concerns about the child's nutritional status, a referral was made to the dietitian.
- Children we spoke with said they liked the food and chose from pictorial menus. Drinks were refreshed throughout the day.
- Infants admitted in the neonatal unit were on feeding charts to monitor their milk input. This was a vital chart to demonstrate whether the infant's clinical condition was improving or deteriorating.
- Breast feeding mums were encouraged to express breast milk so there was a supply for the baby when mum was not present.
- Parents were shown where baby milk formula was kept and encouraged to make up feeds themselves.

Patient outcomes

- The hospital submitted data to the National Neonatal Audit Programme. The audit programme is based on a set of performance indicators that provide a robust measure of a provider's quality of care. The information is compared with a national average and can be benchmarked to other neonatal units or networks.
- The hospital performed equal to or better than the national average in six out of 12 audit outcomes in the national neonatal audit programme (NNAP). It was noted that in the 2016 NNAP, two additional audit criteria were added, these were provision of magnesium sulphate to mothers 24 hours after giving birth to babies below 30 weeks of gestation and numbers of babies with a positive culture growth from a central line (a catheter inserted into a large vein which usually delivers medication or fluid) after 72 hours of life (measures per 1000 line days). We did not see an action plan to address how the hospital could improve on the outcomes which were worse than the national average.
- A neonatal sepsis audit conducted in January 2016 showed 92% of babies screened appropriately but a delay in administering antibiotics in 41% of cases (that is antibiotics not administered within the first 'golden' hour). We also reviewed the baseline assessment tool for NICE antibiotics for early onset neonatal infection which showed that the recommendations were not being met.
- Data showed that in the 2014/15 diabetes audit for Lincoln County Hospital performed worse than the England average. There were fewer patients having an

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HbA1c value of less than 58 millimole (mmol) compared to the England average. The mean HbA1c was higher than the England average. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol and 58 mmol (6.5% and 7.5%)."

- The data shows that between March 2015 and February 2016 there were no emergency readmissions after elective admissions at United Lincolnshire Hospitals NHS Trust among patients in the under one age group.
- Between April 2015 and March 2016 the trust performed better than the England average for the percentage of patients under the age of one who had multiple readmissions for asthma, diabetes and epilepsy.
- The trust performed better than the England average for the percentage of patients aged one to 17 years old who had multiple readmissions for asthma, diabetes and epilepsy.

Competent staff

- Staff told us they had annual appraisal meetings with managers and they were meaningful and relevant.
- The hospital told us that appraisal rates for staff on Rainforest and Safari wards at the time of our inspection was 96.2% which was above the trust target of 95%.
- Staff completed a paediatric early warning score (PEWS) competency assessment tool to enable them to accurately identify a deteriorating child.
- Neonatal service staff attended a development programme one day per year which enabled them to remain current and competent.
- Staff in the outpatient department did not have paediatric life support training. Assurance of safe care and treatment of a paediatric patient in cardiac arrest could therefore not be provided.
- Basic life support for paediatric simulation exercises took place on the neonatal unit. The exercise was recorded so staff could review their performance and identify any areas for improvement.
- There was a rigorous process for medical revalidation through portfolio reviews and appraisals. There was currently one medical appraiser due to consultants leaving the hospital.

- There was an induction process for locum doctors who worked at the hospital. Before they arrived at the hospital, they were required to send their curriculum vitae through to the head of service who assessed them for suitability for the position.
- There was a paediatric consultant responsible for paediatric doctor trainees. The hospital had robust processes in place for the induction, training, supervision and development of paediatric doctor trainees. This included the management of staff who were under performing.
- Trainees were given an opportunity to raise any issues at the monthly trainee forum. We saw the minutes of the August 2016 and September 2016 Trainee forum meetings, topics raised included induction, ward rounds and relationships with ward staff.
- A Deanery review in 2015 reported that paediatrics were a good performing area.
- Induction plans were in place for all new staff including bank and agency staff. We saw induction plans for the paediatric and neonatal wards. In addition to the written plans there was an on line paediatric induction package for medical staff.
- Paediatric and neonatal trainers supported staff developing competencies. A dedicated seminar room was allocated which had simulation equipment and teleconferencing equipment.
- Nursing staff told us there had been training sessions provided by the hospital to help them with the Nursing and Midwifery Council (NMC) revalidation process.
- There were nine members of staff qualified in the European paediatric life support (EPLS) between the two paediatric wards; this did not give them sufficient quantities of suitably qualified staff.

Multidisciplinary working

- In the CQC children's survey 2014 the trust scored about the same as other trusts. For the question 'Did the members of staff caring for your child work well together?'
- We reviewed end of life care provided to a patient and their family and found effective multidisciplinary working between hospitals and teams within hospitals. The services involved multidisciplinary staff working between two hospitals, chaplaincy services, bereavement services, community palliative care, genetics, ambulance service, mortuary services and medical and nursing staff on the neonatal unit.

Services for children and young people

- Staff described good working relationships with ward based staff including physiotherapists and occupational therapists.
- Young people transitioning from the paediatric diabetes clinic undertook a transition period of 12 months and followed the trusts paediatric diabetes multidisciplinary services transition policy. The paediatric consultant transferred the young person to the transition clinic where both paediatric and adult teams were involved in the care and treatment plans and worked alongside each other.

Seven-day services

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

Access to information

- Staff did not use the personal child health record (PCHR) regularly. However they told us that if they administered a vaccination to the child or young person they would enter the details in the record if the parents provided them with the record. We did, however see evidence of the growth charts found in the PCHR in the medical notes of those children and young people admitted into the ward areas. These were updated when or if the child was admitted or seen in an outpatient clinic. Staff were unsure if this information was transferred into the child's PCHR.

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

Consent

- The trust's consent for examination and treatment policy supported making the patient's best interests central to the process of obtaining consent. If a young person was under 16 and wished to consent to their own treatment, staff followed Gillick Competency to assess whether the young person would have the maturity and intelligence to understand the risks and nature of treatments. The young person would be given time to consider all the options. Staff on the children's ward told us they would encourage all young people to be involved in their consenting process.
- The annual consent audit, completed in July 2016 showed the service was compliant with 20 out of the 29 standards. One of the standards showed the service completed 100% of consent forms in advance of the procedure being conducted. The action plan which accompanied this recommended that all consent should be reconfirmed the day of the procedure. Other areas which the audit results showed non-compliance against included copy of consent form given to parents, copy of the consent in the notes, leaflet provided to the parents/patient and special requirements recorded.
- Staff told us they had not received any restraint specific training at the trust however they completed conflict resolution training. They also told us they had not been in a situation where they would require restraint techniques to be applied.
- The hospital reported that 97% of staff on Rainforest and Safari wards had attended Mental Capacity Act and Deprivation of Liberty training.

Services for children and young people

Are services for children and young people caring?

Good



We rated caring as good because:

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

Compassionate care

- The trust performed about the same as other trusts for 10 out of the 11 questions relating to compassionate care in the CQC children's survey 2014. The trust performed better than other trusts for the question 'Do you feel the people looking after you were friendly?'
- Staff told us there was an annual service for bereaved parents led by the hospital chaplain.
- We reviewed an end of life case study on the neonatal unit. The study demonstrated a high level of thoughtful compassionate care including bereavement support and chaplaincy services.
- Staff in the nuclear medicine department told us that children attending for a nuclear medicine scan have their cannula inserted on the children's ward to avoid distressing the child.
- We observed good interactions between staff, children and the relatives. All staff communicated appropriately with the children. Relatives told us staff were wonderful.
- We saw play specialists using books to explain to children the surgery process from admission to discharge.
- In preparation for a child returning from surgery staff had placed a toy dinosaur in his bed complete with complementary bandaging.
- On the neonatal unit we observed nursing staff cuddling, rocking and singing to babies.
- Staff were respectful and always asked permission before carrying out treatment or procedures.

- The Friends and Family Test (FFT) was a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Information received showed the Friends and family test (FFT) results for Rainforest and Safari Ward varied with between 60% and 100% of respondents recommending the NHS service they had received to friends and family who needed similar treatment or care. There were no responses available to explain the variable rate for this, however it was noted that the results were based on low response rates.
- The most recent results for the FFT were October 2016. This showed 91% of those who participated would recommend Rainforest Ward and 67% would recommend Safari Ward to their friends and family.
- You said we did was used on Nocton Ward. We saw examples of feedback form parents who had used the services on the ward, as well as actions taken to improve areas parents had felt needed improving.
- Staff on Nocton Ward provided activity bags for siblings of infants admitted on the ward. Relatives told us they thought this was very caring of them and appreciated the way they were trying to involve them whilst on the ward.

Understanding and involvement of patients and those close to them

- In the CQC children's survey 2014 the trust scored about the same as other trusts for the question 'Did a member of staff agree a plan for your child's care with you?'
- In the CQC children's survey 2014 the trust performed about the same as other trusts for 15 out of 15 questions relating to understanding and involvement of patients and those close to them
- All parents and relatives we spoke with said they had been given a full orientation to the ward and facilities including where to park and how to obtain a parking permit.
- The end of life study we reviewed demonstrated how staff involved families in the care planning process. Staff facilitated the mother taking the baby for a walk in a pram, caring for the baby in a dedicated room and making a room available for the mother to stay at the hospital.
- Staff in the radiology department told us they worked flexibly with the wards to accommodate a suitable time

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for children to attend the x ray department to minimise anxiety. Parents were allowed to escort the children into the x ray room and wore protective clothing throughout the x ray procedure.

- Staff displayed extra sensitivity to children attending the attention deficit hyperactivity disorder (ADHD) and autism clinics; children were greeted and shown immediately to a calm area in order to reduce distress.
- All the parents and relatives we spoke with said medical and nursing staff had kept them informed at every stage of the care and treatment. They allowed time to answer questions and gave information in simple terms that was easy to understand. Parents felt they were part of the decision making process.
- We observed a member of staff taking a blood sample from an older child. Explanations were given at every stage to the child and mum and praise and encouragement was given throughout the procedure.
- Staff facilitated parents accompanying their child into the anaesthetic room and then joined them again in the recovery area after the operation to provide emotional support and comfort to the child.

Emotional support

- In the CQC children's survey 2014 the trust performed worse than other trusts for the questions relating to emotional support 'Were you told different things by different people, which left you feeling confused?'
- We observed nursing staff comforting parents and relatives when they were visibly upset and spending time with them to allow them to discuss their feelings.
- Children told us they could easily ask medical and nursing staff about anything that was troubling them.
- Parents told us they felt confident leaving children in the care of the ward staff.

Are services for children and young people responsive?

Good



We rated responsive as good because:

- Children were recovered post-surgery in a dedicated paediatric area.
- Children and young people were able to keep in touch with relatives and friends whilst admitted.

- The hospital involved parent groups in the planning and delivery of services so that they met the needs of the local population.
- There were facilities available for families to stay with their child during admission.

However:

- Further work was required for transition clinics due to the limited availability at the hospital.
- We could not be assured that staff followed the DNA policy for the children's outpatient department.
- The hospital did not have a lead for children with learning difficulties or complex needs.
-

Service planning and delivery to meet the needs of local people

- In the CQC children's survey 2014 the trust performed better than other trusts for one out of two questions relating to responsiveness Did you have access to hot drinks facilities in the hospital? The trust performed about the same as the England average for the question 'How would you rate the facilities for parents or carers staying overnight?'
- The hospital allowed flexible visiting times for carers and provided them with a badge which enabled staff to recognise the arrangement.
- The neonatal unit had three bedrooms, two ensuite, for parents. Parents were also given free parking subsidised meals and access to hot and cold drinks on the unit.
- A carer's charter was in place and we saw this displayed throughout the hospital, it detailed what support carers could expect when visiting the hospital.
- There were two parent groups, Kangaroo Club and the Parent Advisory Group. The hospital used the groups for service consultation or to review new documentation such as parent information leaflets.
- There was a dedicated paediatric recovery area in the operating theatre.
- The hospital did not have a transition lead but three members of staff attended transition conference in September 2016 and were developing an action plan. There was no specific training available for staff to attend on children transitioning to adult health services.
- Children were allowed to use their mobile phones and other devices to keep in touch with their friends on social network sites.

Services for children and young people

- Visiting parents and families had access to tea and coffee making facilities.

Access and flow

- The trust Patient Access Policy, January 2015, described what patients should expect following referral to the hospital. It also included staff training on the policy and annual audit for quality assurance purposes.
- The policy was supported by a comprehensive document consisting of action cards which described each stage of the patient journey in relation to referral and appointments, it also included cancelled appointments, management of 'Did not attend' (DNA's) appointment, waiting list and cancer waiting times. Staff told us that children who did not attend an appointment were always offered a second appointment. We were told if they did not attend the second appointment and could not be contacted by telephone a safeguarding referral was made to their local safeguarding service.
- Between November 2015 and October 2016 there were 2003 children who did not attend their appointment in the paediatric outpatient clinic. Of these 1116 were given, and attended, a follow up appointment. No details were provided for the other 887 children who did not attend their appointment. This meant we were not assured that these children had been followed up in accordance with the trusts policy.
- Referral to treatment rates were above 90% for ten out of twelve months between August 2015 and September 2016. The NHS constitution pledge says patients should have a hospital appointment within 18 weeks of the day the hospital first receives the referral letter.
- Between April 2015 and March 2016 the median length of stay for elective admitted patients under the age of one was similar to the England average. The median length of stay for emergency admitted patients under the age of one was lower than the England average.
- Between April 2015 and March 2016 the median length of stay for elective and emergency admitted patients aged one to 17 years old was similar to the England average.
- The 2016/2017 patient's and children's business plan showed that there was a temporary reduction in beds on rainforest ward (24 to 19) and cots on the neonatal unit (15 to 10).

- The hospital had one transition clinic for children with diabetes, staff at the clinic worked with the children's diabetes services at a regional acute hospital.

Meeting people's individual needs

- The hospital did not have a lead for children with learning difficulties or complex needs. Staff told us they would involve the learning disabilities community nurse specialist if they identified a child who required this specialist input. The hospital did not have their own paediatric learning disabilities nurse.
- There was a trust wide operation policy in place for the management of paediatric diabetes dated February 2016. The policy clearly outlined the patient pathway and role of the paediatric diabetic team, outpatient services audit and patient feedback.
- Translation services were available but staff in the outpatients department told us that interpreters were not always available for first appointments.
- The hospital published a selection of patient information leaflets for example we saw leaflets for circumcision, bowel management and myringotomy (surgical procedure to reduce the pressure in the ear) and insertion of grommets (a tube placed in the ear to drain fluid). In addition notice boards contained more information such as information about the Tommy's premature baby application for mobile phones and devices and BLISS (a charity for parents with a premature and sick infant).
- Breast feeding mums were given access to adequate food and drink whilst at the hospital.
- Chaplaincy and bereavement services were available for parent and families who required their input. Chaplains at the hospital held a yearly celebration of life for babies that had died whilst admitted. This provided parents with the opportunity to provide peer support to others and also seek further emotional support through the chaplaincy department if required.
- Since the last inspection, a child and adolescent mental health service (CAMHS) crisis response team were introduced who reviewed patients in the emergency department with a view to preventing admissions. If a child requires admission, the CAMHS professionals would review the child on the ward with a view to transferring them to an appropriate environment if required.

Learning from complaints and concerns

Services for children and young people

- Information was displayed in the ward areas which provided details of how to complain.
- Children and relatives told us they knew how to make a complaint if they felt they needed to.
- Parents told us they knew how to access the Patient Advice and Liaison Service (PALS) if they had any concerns with care they wished to raise. We saw the PALS log for paediatric concerns for July, August and September 2016. There were 19 entries in total and each had a description of the outcome and any action arising from the concern. All of the concerns had been resolved.

Are services for children and young people well-led?

Good



We rated well-led as good because:

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

Vision and strategy for this service

- The Trust had a five year plan which contained plans for children and young people's services. The plan recognised current ways of working were not sustainable and were currently in a consultation period over the future of children's services provided by the trust. Leaders were aware of the plan and kept all members of staff up-to-date with developments.
- The trust vision and values were displayed in the children's ward and neonatal unit, and staff were aware of these.

Governance, risk management and quality measurement

- Paediatric services were included in the patient's and children's services business unit headed by a clinical director.

- There was a non-executive director (NED) who represented the children and young people's services at board level meetings. Senior staff told us they engaged with the NED and they had visited the children's ward area.
- There was a robust governance structure within the business unit. Clinical, operational and business meetings took place monthly which meant staff had an informed picture of the efficiency and effectiveness of the unit and where remedial or mitigating actions were required. The meeting fed in to the trust wide governance meetings.
- There were clear lines of communication for governance, risk management and quality measurement which cascaded information from the board level to ward level, and vice versa.
- Results of audit were discussed at the clinical governance meeting including action to take from findings.
- Paediatric and neonatal clinical governance meetings were held monthly. We reviewed the minutes of two meetings and found the contents relevant to a clinical governance agenda and included morbidity and mortality.
- Risks were identified and managed. We saw the neonatal and paediatric risk registers dated August 2016. Risks were clearly identified red, amber green rated and mitigating actions allocated.
- We checked six trust policies all had been reviewed within the last 12 months.
- Local safety standards for invasive procedures (LocSSIPs) were produced for the children's services to provide safer care and reduce patient safety incidents. These reflected the details contained within the national safety standards for invasive procedures (NatSSIPs) where it was advised local safety standards are produced for procedures which could result in a never event. An example of a LocSSIP produced by the hospital was for passing nasogastric (a tube passing through the nose into the stomach) or orogastric (a tube through the mouth into the stomach) tubes in neonates and the insertion of long lines in children in addition there was a management record for peripheral cannulation including a visual infusion phlebitis score.
- The board received an annual safeguarding report.

Leadership of service

Services for children and young people

- Leaders demonstrated skills and knowledge to perform their roles competently and were visible in the wards and areas we inspected.
- Staff told us they regularly saw members of the executive team and senior managers were visible even at weekends,
- Ward leaders completed ward assurance ward rounds. These included speaking to a sample of patients and relatives, checking patient records and charts, and making sure patients were receiving basic nursing care in line with best practice. Any issues identified during the ward round would be escalated as necessary and feedback given to staff in particular recognising good practice.
- All consultants had up-to-date job plans for their roles. Staff told us they were imminently going to implement electronic job plans once some final refinements had been made.

Culture within the service

- Staff told us they felt involved, motivated and engaged and managers listened to their concerns. However they told us they felt separate to the other hospitals in the trust.
- Team de briefing sessions were planned following the death of a child or baby.
- The trust held annual award ceremonies. Staff from the service had been nominated for the 2016 awards in categories such as going the extra mile, unsung hero, outstanding leader, team of the year.
- The trust utilised twitter and Facebook to improve communication with staff.
- All staff spoke about how their main focus was providing excellent care to the children and young people who used the service. This was the one thing they were all proud of and passionate about.

Public engagement

- Parents and family members were automatically given survey/feedback cards. We saw parents completing feedback cards.

- Children and their parents engaged with the implementation of a new menu. A questionnaire was given out asking what they would prefer; a new menu was trialled before full implementation.
- The children's service had a twitter page where parents were able to voice their comments (tweet) about the service. This was real time information and staff were able to view and respond back to the parent/guardian.






Staff engagement

- Staff took part in a staff survey and told us they felt their opinions were taken seriously. Staff and leaders told us they recognised the importance of raising concerns in order for them to be addressed.
- The lead for medical training in the service received an award in recognition of the improvements to the training programme at the hospital.

Innovation, improvement and sustainability

- A business case was submitted to fund two paediatric high dependency beds within Rainforest Ward. This would improve the quality of a service already being provided due to additional funding for staff training and increase in equipment.
- The trust had devised the 'ready steady go' transition plan, which supported children with a long term illness to transition between children's services and adult services. The plans were produced with the child to identify when the transition would best suit them and improve the experience of transitioning between services. However, we did not see any evidence during our inspection of this being used.
- Nocton ward had relocated during our inspection due to refurbishment work taking place. These improvements being made would modernise the environment and improve the facilities available for parents using the service.
- Staff on Nocton ward had taken the initiative to provide sibling activity bags for any siblings of the infants admitted on the ward. This had improved the service from the relative's perspective and the ward had received positive feedback in regards to these.

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

Information about the service

Lincoln County Hospital is one of seven main sites delivering outpatient services across Lincolnshire to a population in excess of 720,000. From March 2015 to February 2016, the Lincoln outpatient department provided approximately 460,000 outpatient appointments.

Outpatient services were provided for a wide range of specialities, including general and specialised surgery, urology, ophthalmology, general medicine, haematology, diabetic medicine, rheumatology, dermatology and neurology.

Lincoln County Hospital also provides a wide range of diagnostic imaging services, including general radiography, computed tomography (CT), ultrasound, magnetic resonance imaging (MRI), nuclear medicine, cardiac imaging and interventional radiology. Radiology and outpatient services are managed within the clinical support services business unit.

Patients could access outpatient clinics located across two floors via the main outpatient and main hospital entrances. A central reception desk was located on the upper floor and self-check in terminals were adjacent to the central reception and in clinic areas. Clinics had their own waiting areas.

During our inspection of the outpatient department, we spoke with 25 patients and relatives, and staff from all clinic areas. This included senior medical staff, business unit

managers, nursing staff including clinical nurse specialists and matrons, administration staff including reception and booking, staff in the health records department and medical secretaries.

During our inspection of diagnostic services we visited the main and A&E radiology departments, magnetic resonance imaging (MRI) department, breast imaging, ultrasound, DXA and nuclear medicine. A DXA scan is a special type of X-ray that measures bone mineral density. We spoke with four patients, 20 radiographers, three sonographers, one doctor, two nurses, two technicians, three medical physicists, three clerical staff and two managers. We also observed three procedures.

We reviewed patient notes following outpatient appointments, computerised appointment records and clinic letters and looked at outpatient policy documents. We observed the staff and patient interactions, considered the outpatient environment and reviewed performance data provided by the trust.

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Summary of findings

We rated outpatient and diagnostic services as requires improvement overall.

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

- The concerns we found during this inspection were the same as our findings in 2014 and 2015, this was despite actions plans to address the areas of concern following both of these inspections.
- There was a potential risk to patient safety because managers did not always share learning from incidents with all staff. Safety procedures and maintenance contracts were not always in place to ensure the environment and equipment were adequately assessed, risks identified and equipment maintained.
- Nursing staff were not always managed effectively as not all staff had received up to date mandatory training. Medical staffing vacancies affected the trust's ability to meet the demand for outpatient services.
- The condition of patient health recording had a negative impact across all clinic areas and posed a potential risk to patient confidentiality. The lack of availability of records affected most clinic areas.
- We saw significant numbers of patients overdue for appointments including new and follow up appointments. Performance against some cancer waiting targets was consistently below the national standards placing patients at risk of potential harm from delayed treatment. Where the trust made progress to address the backlog of waiting list appointments this negatively affected the trust meeting the referral to treatment standards for new patients across many specialities.
- Data showed 8,108 patient appointment outcome records, which had not been completed and closed on the electronic record system. Data supplied by the trust showed the current position was worse than the previous year.

- The trust had not maintained an accurate record of patients who required outpatient appointments. The trust was tracking thousands of computer records to establish the patients who should have received appointments.
- There were delays of up to several months in the reporting of some diagnostic reports due to failures in the information technology systems used by the regional picture archiving and communication system (PACS).
- Progress against some poor performance and identified risks was slow. We saw issues identified since our last inspection had not been comprehensively addressed for example, overbooking of clinics. Reports showed there had been long standing issues for example, condition of health records, which the trust had not addressed.

However we also found:

- Staff provided patients with evidenced based care and treatment and followed national guidelines. Patients received care delivered by staff that were experienced, skilled and had knowledge to deliver care that met patient's needs.
- Staff in outpatient and diagnostic services provided a caring, professional and compassionate service. Staff ensured patients received the best possible care. Patients were happy with the care they received. Staff had been flexible and worked their weekends to provide additional clinics in many specialities to try to meet the demand for outpatient services.
- Diagnostic radiology services delivered care and treatment in a safe environment. Systems were in place to protect patients from harm during radiological investigations and ensured compliance with the departments legal responsibilities.

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Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated the safety of the outpatient and diagnostic services as requires improvement because systems were not in place to protect patients from potential harm

- Where staff had reported incidents, the appropriate grading had not always been applied. Where incidents had been investigated not all staff knew the outcome of investigations. These meant patients may be at risk of otherwise preventable harm.
- Staff did not give infection prevention and control sufficient priority; staff used environments for more than one purpose, equipment was not maintained, this posed a risk to patient safety from infection. Staff did not manage risks in the environment in a way to prevent or control the risk of infection to patients.
- Health records were not always available at patients outpatient appointments.
- Not all outpatient and diagnostic staff had completed their mandatory training with completion rates below 75% for several subject modules.
- Medical staffing vacancies were having a direct impact on the ability of the trust to meet the demand for outpatient services. This placed patients at a risk of harm for a delay in receiving appropriate treatment.
- There were internal systems in place to monitor and ensure the safety of patients. undergoing radiological investigations or procedures however, these procedures where not always being adhered to
- As of the week of our inspection, there were 8,108 patient appointment outcomes, which staff had not completed and closed on the electronic record system. Data supplied by the trust showed the current position was worse than the previous year. This presented a risk to patients in their ongoing treatment and care. Following our inspection the trust had forecasted the numbers of incomplete outcomes to fall by half in early 2017.
- Data from the trust showed a significant number of patients who had been missing on the electronic patient administration system. Of these, 18% required a further appointment meaning they had been missing from the

waiting list. There was an ongoing process to continue to identify further patients missing from waiting lists. This presented a risk to patients' ongoing treatment and care.

However, we also found

- All staff complied with infection and prevention control measures; all staff were bare below elbow in clinical areas and carried out appropriate hand hygiene prior to patient contact. This was in line with trust policy.
- Staff complied with the processes that were in place to manage medicines and new clinic standards included measures to help keep patients safe from harm.
- Staff gave safeguarding sufficient priority. Staff were knowledgeable and confident in their responsibilities to protect patients, their friends and families from harm.

Outpatient Incidents

- Staff used an on line reporting system to report incidents and all staff were familiar with the process of reporting incidents and accidents.
- There were no never events in this service from January 2016 to June 2016. Never events are serious incidents that are wholly preventable, as guidance or safety recommendations that provide strong systematic protective barriers are available at national level. These should be implemented by all healthcare providers. Serious incidents are events in health care where there is a potential for learning or the consequences are so significant they warrant using additional resources to mount a comprehensive response.
- From June 2015 to June 2016, outpatient and diagnostic services reported 497 incidents. A wide range of departments filed reports. The majority of incident records had been reviewed and closed. All reports contained a record of initial actions that had taken place but in the majority of cases, there were no actions recorded of the steps taken to prevent similar incidents in the future.
- There were four incidents graded as severe and these all related to delays in a diagnosis being established which resulted in patient harm. The majority 407 of the incidents had been categorised as no harm. These no harm incidents included four breaches of patient confidentiality where patients had received another patient's outpatient appointment letters. These had contained personal medical details. Other incidents

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reported as no harm included a cancelled patient appointment due to unavailable equipment. Harm from a breach in confidentiality or cancelled appointment had not been recognised.

- The most frequently reported incidents, related to patient records, there were 105 incidents including misfiling records and unavailable records for clinics.
- Staff gave examples in what circumstances they would report an incident, including personal accident and if equipment had failed. Staff did not always report when patient's notes were not available for the start of a clinic, some staff explained it would depend on whether there was any impact on the patient. Managers reminded staff to report missing notes during a team briefing we observed.
- We reviewed the fracture clinic team meeting minutes from May 2016. This meeting had covered serious incidents and department incidents, which were reported as standard agenda items.
- Staff had varying degrees of knowledge of past incidents, a senior member of the administration staff was not aware of the serious incidents that had taken place in the trust and would not expect the administration team to know. Nursing staff received updates from the clinic lead nurses, one nurse was aware of a never event which had been reported by the hospital. Staff explained they discussed serious incidents during staff huddles. These were short daily briefing sessions held before clinics commenced.
- Some staff we spoke to gave us examples of where learning had taken place following an incident. These included clearer identification of the sample collection point to ensure samples are always collected, and a change to the procedure to ensure patients waiting for transport after the clinic had finished are made known to a member of staff to ensure their safety and well-being.
- The duty of candour is a regulatory duty which relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to the person. All staff knew of the need to be honest and open with patients and their relatives. Staff were able to identify where the duty of candour process had been

implemented. This included when there had been a delay in a sample being analysed. Incident report records provided evidence staff applied the duty of candour process.

Diagnostic Imaging - Incidents

- NHS trusts are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R. Diagnostic imaging services had procedures to report incidents to the correct organisations, including CQC
- Every radiographer we spoke with knew how to report incidents that occurred within the department. There had been six radiation incidents reported to the CQC over the 12 months preceding the inspection. The trust had investigated all of these incidents and had put measures in place to reduce the likelihood of similar events happening in future.
- Every radiographer we spoke with knew what 'duty of candour' was and all said they would be open and honest with a patient if something had gone wrong. We also saw screen-savers displayed on computer screens to remind staff about duty of candour.
- Staff told us they felt confident to raise concerns because they felt management would listen to them.
- Staff explained managers shared feedback and learning from incident investigations during staff meetings as well as at the daily morning briefings. Radiology management told us any changes to practice implemented following an incident were often communicated to staff by email. However, this was done on an ad hoc basis. A small number of radiographers told us there was a lack of feedback from incidents that involved radiology when investigated by departments outside of radiology.
- Bi-monthly medical exposure committee meetings included discussions on incidents and any learning from incident investigations. Actions from these meetings fed into the radiation protection committee, which meets three times a year.
- Local rules were seen as required under Ionising Radiations Regulations 1999 (IRR99) and were within review dates. IRR99 are a statutory instrument, which form the main legal requirements for the use and control of ionising radiation in the United Kingdom.

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- The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) procedures were in place and all documentation was available on a shared drive. This ensured only the most recent versions were available for staff to reference.

Cleanliness, infection control and hygiene

- All equipment was visibly clean. Staff applied labels to equipment to identify when they had been cleaned.
- All staff, without exception, were bare below the elbows. We observed medical, allied health professionals and nursing staff using the appropriate personal protective equipment (PPE).
- Hand gel was available in all clinics but was not always in a prominent position, and not always at the entrance to the clinic area, there was limited signage informing visitors and reminding staff of the importance of hand hygiene.
- The outpatient department conducted monthly hand hygiene audits as part of the department's internal audit programme. In July 2016, audit data from 14 outpatient department areas covering all members of the multidisciplinary team, 456 out of the 560 hand hygiene observations as compliant with the infection control policy. Staff recorded actions taken to address any areas of concern.
- Clinical wash hand basins were located in the examination rooms. Clinic examination room doors were closed when they were not in use.
- Waste bins were located in all departments and clear signs and colour-coded bags identified which bins were for clinical and which were for domestic waste. Staff appropriately segregated waste prior to disposal, and placed waste waiting for collection in suitable locations.
- Staff signed and dated sharps bins when using them. Staff stored the bins appropriately when sealed and ready for collection.
- Managers implemented outpatient department standards in some clinics. This included a clean down procedure to be undertaken at the end of each clinic. On completion a 'green is clean' sticker was placed on the inside of the examination room doors. We saw this sticker in use and the rooms we reviewed were visibly clean. .
- The trust carried out cleaning audits in 19 areas of the outpatient department, including clinics and waiting areas. From November 2015 to April 2016, 35 audits had been carried out. In 24 of these audits, the standard of cleanliness did not meet the trust target.
- We saw evidence from a cleanliness inspection report from April 2016 that showed an overall compliance rating of 94.2% for radiology departments. The actions from this audit included cleanliness audit results as a standing item for senior staff meetings and to increase the frequency of audits in the poorer performing areas.
- In a patient led assessment of the care environment (PLACE) carried out April 2016 four outpatient department areas were assessed. The hospital was assessed as being below the national average for cleanliness with a score of 93.1% the national average being 98.1%. There had been an increase in the hospital site cleanliness score from the previous year's assessment when it was 90.9%.
- In response to these audits the trust had there had been action taken to improve the standard of cleanliness, a deep clean had taken place in some areas and a change was made to the housekeeping schedule. Improvements in the audit data had been noted.
- In clinic six a room was identified as a clean utility which contained medicine cabinets, the storage sealed sterile items and preparation areas. This room also contained an area being used as a staff kitchen. We raised this at the time of inspection with the staff in the clinic who explained a limited amount of space was the reason for the room having a dual use. We returned to the clinic on the unannounced inspection and the use of the room was unchanged. Staff confirmed it was still being used as a dual purpose room. Following the inspection we received information from the trust; initial steps had been taken to address the concerns. Staff beverage facilities had been moved to the nursing office.
- In clinic six a room identified as a scope decontamination room contained the scope cleaning equipment and also a sluice sink. Staff explained the sink was used very occasionally for the testing of urine. We raised this during the inspection. When we visited the clinic on the un announced visit the use of the room remained unchanged. Following the inspection we received information from the trust, initial steps had been made to look into the sluice sink being removed and they had relocated some recycling bins out of the room.

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- In clinic six, boxes were on the floor of the store room; this made cleaning the area more difficult.
- There was a clear documented policy in place for the decontamination of scopes being used in clinic six. The guidelines were readily available to staff and local guidelines referenced national standards. There was a written record of traceability for where the scope had been used and the cleaning that had been completed.
- A trust infection control and decontamination of equipment audit had been carried out in November 2014. This audit had highlighted concerns similar to those identified on inspection. Recommendations were that clinical areas must only be used for their designated purpose; this included the scope decontamination room. The trust provided the results of two cleaning audits for clinic six, completed during 2016. In October 2016 the clinic area attained 93% compared to 78% earlier in the year.
- We saw daily cleaning checklists in interventional radiology, A&E X-ray and nuclear medicine were up-to-date and completed appropriately. 'I am clean' stickers were used in most areas.
- Staff in ultrasound told us they decontaminate ultrasound probes after intimate examinations in line with manufacturer recommendations however, no records were kept to demonstrate this.
- During our unannounced inspection we noted a drinking water dispenser located adjacent to the main outpatient reception desk was visibly unclean. The outer casing and drain area were heavily soiled. The machine was past its disinfectant date for water hygiene control. This was last completed in February 2016 and should have been completed in August 2016. There was no cleaning schedule adjacent to the machine to indicate when it had last been cleaned or when it was next due for cleaning. Disposable cups were available and these were in a sealed dispenser and were visibly clean. The water dispenser required an electrical supply and there was no record of when it had received an electrical safety test.
- We raised this with the outpatient department matron who assured prompt action would be taken. The two other water dispensers within the outpatient areas were both visibly clean. Both however, both were outside their water hygiene service date and there was no visible electrical safety testing dates on either machine or no cleaning schedules to indicate when they were last cleaned. Following the inspection the trust provided an update of the actions that had been taken to address our concerns. These were comprehensive and put actions in place to prevent the situation re occurring.
- In the haematology clinic staff spoke of their concerns about the cramped waiting room where patients with potential low immunity attending the haematology clinic were placed at an unnecessary risk of picking up an infection. The waiting room was also used by patients waiting for blood tests. We raised this concern with senior managers during the inspection. On our unannounced visit we returned to the clinic, staff explained the waiting room was still being used by both clinics.
- Precautions were taken where patient's had a known infection. We saw the use of an alert sticker in one patient's notes who had a known risk of having an infection. Care was planned to minimise the risk of spreading infections. Clinics used infection, prevention and control link nurses to ensure staff were kept updated with current policy.

Environment and equipment

- The outpatient clinics were located on two floors, with access via stairs or lifts. There was a central outpatient reception desk which was located on the upper floor. This was located adjacent to quite a large visitor refreshment area. From observing this area on several occasions during the inspection we noted when the area was busy there was a persistent background noise; this could have impacted on patients speaking with staff at the desk. Staff we spoke with confirmed at busy times the noise was a problem.
- During the inspection we observed most clinic waiting areas to be quiet, with sufficient seating to accommodate all the patients were attending. Clinic seven was very busy, patients attending for haematology appointments and the patients waiting to have blood tests waited in the same area. Patients waited in the main waiting area and in an adjacent corridor. Patients requiring blood tests were from other clinic areas in the hospital or had come at the request of their GP. This made this environment very busy.
- Each department or clinic area had a toilet which was well signposted. All clinic signs were clear, and patients we spoke with had found their clinic area with minimum difficulty. In the urology investigation unit there was just one patient toilet. We were concerned this may not be

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adequate as patients were attending for investigations relating to their urinary tract and may require toilet facilities frequently or at short notice. Senior staff explained there had been no complaints about the toilet facilities however, a review of the department was being considered and this would be noted.

- Fire exits were clear and fire escape route signs were displayed. Clinics were generally tidy and corridors kept clear. Health records and secretary offices had limited space, large numbers of patients health records caused areas to become cluttered.
- On our previous inspection in 2015 we had been concerned procedures were being carried out in outpatient clinic rooms which were not suitable for that purpose as they had insufficient lighting, air flow and ventilation. A review was completed following the inspection and major procedures were now carried out in the operating theatres. Air conditioning had been installed into procedure rooms.
- The hospital's equipment maintenance team were responsible for the maintenance and safety checks on the equipment throughout the main outpatient department. Electrical equipment was labelled to ensure traceability and most equipment included a label dating when the last servicing and checks had completed.
- In the outpatient physio therapy department there were large exercise equipment of the same appearance to those found in a gymnasium. At the time of the inspection senior staff were not able to provide details of the service programme for this equipment. Staff familiar with the equipment carried out observations of the equipment before and during its use however, there were no records made of any daily checks carried out on the equipment. Staff always closely supervised patients when using the equipment.
- One piece of equipment did contain a label with a third party name and a next inspection date but the timeframe for this was unclear, following the inspection we reviewed the equipment maintenance schedule for the physiotherapy department it did not contain any gymnasium exercise equipment. We were not assured that there was an established procedure to carry out routine checks or maintenance of the mechanical parts of the gym equipment. Following our inspection the trust informed us that a maintenance contract was now in place with a third party provider
- Staff checked emergency resuscitation equipment within the department in line with trust policy. Staff checked the oxygen, suction and defibrillators daily and carried out a weekly check of the contents of the resuscitation trolley was. A sealed tag was used to ensure the contents of the trolley was not been tampered with between checks. Senior nurses allocated the responsibility of the checks to staff during the morning briefings in some clinics. In others, staff knew who had responsibility for the checks. We found comprehensive records of completed checks.
- In the outpatient physiotherapy department there was no equipment available to use in the resuscitation of a child. We raised this with senior staff as a concern as children received treatment in the department on a regular basis. Paediatric resuscitation equipment was provided for the department.
- Outpatient department clinics were fitted with emergency call bells in the clinic rooms. There was no planned procedure to check call bells would be working correctly if staff needed them in an emergency. We raised this with the department matron during our unannounced inspection.
- Imaging equipment had regular servicing carried out by manufacturer engineers. We saw the manufacturers completed service reports.
- Staff showed us quality assurance (QA) records for some of the imaging equipment within the trust. The QA records highlighted to staff when measurements were not as they should be. Staff also told us the department had introduced a QA programme for all ultrasound probes within the trust. Ultrasound probes are easily damaged which may affect image quality, therefore regular QA may reduce the likelihood of a poor quality examination.
- Staff told us the stock rotation for the interventional radiology supplies was performed monthly. We checked some of the stock and found it to be in date.

Medicines

- Staff were aware of the policies relating to the safe storage of medicines and associated documentation. We were told patient group directives (PGDs) were in place for all appropriate radiographers. These documents enabled radiographers to administer contrast agents and a very limited number of drugs without an individual prescription from a doctor.

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- The clinic standards informed staff to return the prescription pads for secure storage at the end of the clinic. We did not see any prescription pads left unattended in unsecure rooms, and staff showed us how they recorded the traceability of the prescription pads.
- Staff in one clinic did discuss the potential that doctors could leave the rooms briefly while prescription pads were not stored securely during a clinic but we saw no evidence of this on inspection.
- Staff locked fridges used for the storage of medicines and checked fridge temperatures daily. In one clinic these recordings had been made on a record sheet intended to record freezer and not fridge temperatures. The fridge temperatures however were within range and we informed staff at the time of the inspection.
- We checked the contrast warmers throughout the department and we found all bottles of contrast checked to be in date. We checked the controlled drugs cupboard in interventional radiology. The drugs were in date and records were accurate and up to date. We also checked the drugs in the nuclear medicine department and found those to be in date.

Records

- We reviewed the written record made during the clinic consultation in 15 patient records these entries had been all been dated and signed.
- In the majority of clinics records were stored securely, we saw notes in an unlocked room in two clinics however these were in areas where staff would be accompanying patients.
- Following a clinic appointment, a record was required of what treatment and procedures staff had undertaken, what next steps were required. If a follow up appointment was required, the timeframe for this was included. The trust had changed from a paper to an electronic version of this outcome record in March 2016.
- The Trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patient's radiological images and records are stored securely and access was password protected.
- Radiology management told us the trust was in the process of introducing an electronic referral system. The department was piloting this system in a few areas.

There had been a safety concern highlighted during the pilot resulting in staff not using the system while they addressed the issue. However, radiology management assured us they had fixed the issue.

- We reviewed five patient records on RIS and saw the radiographers had completed them accurately, including the documentation of who checked patient identification. We also saw evidence the radiographers had checked and documented patient pregnancy status in line with departmental protocol .
- Patient health records were in a paper format. We reviewed 30 sets of patient notes and found the condition of patient notes varied considerably. The majority we reviewed were small sets of notes which were in a good general condition. However we also saw four sets of patient records which were considerably larger in a very poor state of repair. Elastic bands were used to contain unsecured paperwork due to the size of the record. There was a risk of loose sheets containing patient medical information could be lost.
- Reviewing the larger sets of records proved particularly difficult, papers were loose and not filled systematically, finding relevant information was not a timely process.
- From incident records supplied by the trust we established patient records were not always available for clinic appointments and patient records had been misfiled in the wrong medical record.
- A standard operating procedure for the actions to be taken when patient records were unavailable had been established in November 2015. This included compiling a temporary set of notes and how to ensure they were traceable. Copies of previous outpatient letters were available to be printed from an electronic patient record system if hard copies were not available in the notes on the day of the clinic appointment.
- A patient records audit had been carried out on 13 days between the end of February 2016 and April 2016. This established the number of patient records that were not available for clinic appointments and if temporary records had been made available. The availability of notes for 2,565 clinic appointments were reviewed from 245 clinics. One hundred and five (4%) of patient notes were missing and temporary sets had been made available on 23 (22%) occasions.
- An audit programme of health record audit had recently commenced where a different clinic was audited each month for the availability of patient records. In September 2016 clinic 11 records were audited over a

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two week period. On average 85% of patient records were available at the start of the clinic. In one clinic 67% of records were available however in four out the 32 different clinic codes audited all the records were available. We spoke with staff in clinic 11 who had not received any feedback from this audit.

- During our inspection staff in all areas of the outpatient departments and all grades of staff explained notes being unavailable for patient's appointments was a major concern. This generated a lot of additional work for clinic nursing and administration staff as well as medical staff. Health records staff were contacted to locate missing notes but notes were not always available in time for clinics, notes could be located at a different site or when a significant number of notes were missing for one clinic there was insufficient time for them to be found.
- To ensure previous clinic letters could be accessed on the electronic record system a selection of staff throughout the departments had been given specific computer access for this purpose.
- Staff felt patients added late to clinic lists and when notes were at other sites were two of the main reasons notes were not always available.
- Staff from several clinics explained when temporary notes were produced then these were not always than amalgamated, some staff believed a request had to be made for this to be done. Staff explained patients ended up with multiple sets of notes.

Safeguarding

- The trust set a mandatory safeguarding target of 95% for completion of safeguarding training. As of August 2016, 91% of diagnostic staff, 66% of outpatient management staff and 95% of therapy staff had completed level one safeguarding children training. For medical staff 82% of diagnostic and 100% of therapy staff had completed safeguarding children level one training.
- For safeguarding adults level one 82% of diagnostic and 100% of medical staff had completed their training. For non-medical staff 91% of diagnostic, 62% of outpatient management staff and 95% of therapies staff had completed their training. Therefore, outpatient and diagnostic services met its target for therapies non-medical staff safeguarding training but did not meet its target for diagnostics or outpatient management or medical staff.

- Female genital mutilation (FGM) is defined as the partial or total removal of the female external genitalia for non-medical reasons. The trust made information available to staff about FGM in their policy on domestic abuse.
- Staff we spoke with had a good understanding of what their safeguarding responsibilities were. They were able to identify what types of concerns required a safeguarding referral, these included signs of physical and mental abuse. Staff were aware their responsibilities extended to patient's relatives and carer's as well as for the patients themselves. Staff would seek the help of more senior experienced staff or complete a safeguarding referral themselves.
- The trust had recently established safeguarding champions across the trust. The trust had provided staff with information about this and departments displayed it on information boards.
- Staff information also included key information from the trust's safeguarding policy on the responsibility of a line manager in dealing with a safeguarding concern
- We asked staff across several outpatient departments and at least one member of staff in each area could recall instances where a safeguarding referral had been made. These included where a child visiting the department had an unexplained injury.
- Radiology management told us four level three training sessions been held for staff within radiology to ensure all staff had received safeguarding training. All staff we spoke with had completed safeguarding training. Staff told us radiology had their own safeguarding leads.

Mandatory training

- The trust provided mandatory staff training via face to face training and on-line courses. Topics included, fire safety, infection prevention and control, resuscitation, information governance, health and safety, equality and diversity and safeguarding.
- The trust target for the completion of mandatory training was 95%. The trust met its target for therapies medical staff mandatory training for the majority of courses, but did not meet its target for diagnostics medical staff in any courses. The trust met its target for non-medical staff, including nurses, for only some of the courses.
- Basic life support had recently become mandatory for all staff. Senior outpatient staff explained there were insufficient places provided on the basic life support

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training courses. This had led to training completion figures being lower than required. The trust had taken action to address this and additional trainers had been trained to enable the training to be cascaded to more staff within a shorter timescale.

- Staff told us, and radiology management confirmed this, permission was not given for staff to attend additional educational courses if they were not up to date with their mandatory training unless there were reasons beyond the staff members control or if the course was to address service delivery needs. Staff felt this was an effective motivational tool for ensuring staff were up to date with their mandatory training. However as of August 2016 medical diagnostic staff had course attendance rates from 9% to 82%.

Assessing and responding to patient risk

- In May 2016 the trust had identified a further potential risk to patient safety. There were patients who were waiting for outpatient appointments that hadn't been included on the partial booking waiting list so would not have been sent an appointment. There was on-going patient record validation process taking place. Data supplied by the trust following the inspection identified there were 67,635 patients who had received initial treatment who may have required a further medical review of their care, but staff had not placed them on the waiting list.
- After the inspection the trust provided us with information showing validators had reviewed 18,636 (17,082 from external, 1,554 from internal) patients. Of these, 1,119 patients (985 external, 134 internal) required a follow up appointment and needed adding to the waiting list. Of the 18,636, there were a further 2410 records queried by the external validation team and sent to the business units for further review. The trust said it was unclear how many records they needed to add to the waiting list.
- Validators had sent the 1,119 records already identified to be added to the waiting list so business units could appoint them and assess any clinical risk. The trust said patient waiting list figures for overdue patients by 6 weeks would increase because of this additional cohort. The trust did not know whether any patient harm had occurred through the follow up appointments not having taken place when expected. Further reviews of an additional 9,000 patients were due to take place.

- During the inspection we asked the trust for the current number of patients who had not had the outcome of their outpatient appointment recorded. As of the week of the inspection there were 8,108 patient appointment outcomes which were not correctly recorded on the electronic record system. This included patients from across the trust's outpatient services including those provided at Lincoln County Hospital. The trust data included a breakdown of when the clinic appointments had taken place, 6,689 were from appointments in October, 834 from September, 308 from August, 180 from July, and 45 from June. E outcomes should be completed immediately after the clinic appointment. Once the clinician had completed the outcome, the administration staff processed the outcome. Data supplied by the trust showed there was a higher number of open e outcomes now than the trust had in October 2015 when there were 6,719 appointments with no outcome recorded. This was when paper outcomes were being used. Following our inspection the trust had forecasted the numbers of incomplete outcomes to fall by half in early 2017.
- Where the outcome of appointments was not recorded, patients were at risk of appropriate action not being taken regarding the care and treatment they needed. We spoke with managers within the medical business unit who explained open e outcomes were reviewed and action was taken by the business unit. Daily reports were available of patients who had attended the medical clinics and had not had their outcome recorded.
- Resuscitation equipment was available throughout the outpatient department. Staff explained if a patient became unwell whilst in the outpatient department, following any immediate lifesaving treatment they would be transferred to the accident and emergency department. Immediate help would be summoned from the hospital's cardiac arrest or medical emergency team.
- Data supplied by the trust included incidents where a patient's condition had deteriorated in outpatient department, immediate assistance had been sought and on-going care had been provided in the accident and emergency department.

Outpatients and diagnostic imaging

- The urology investigation unit had an area designated to care for patients should they become unwell after a procedure this included the facility for a patient to lie down and have some privacy from other patients in the department.
- In September 2015 the national safety standards for invasive procedures were published. (NatSSIPS). The evidenced based standards are applicable to invasive procedures carried out within the outpatient department and aimed to reduce the number of patient safety incidents related to invasive procedures. There was a requirement for all organization's providing NHS funded care to implement local safety standards for invasive procedures. In May 2016 a trust wide action plan had been introduced to develop and implement local safety standards by July 2017 and staff had been identified to take this forward within the relevant areas of the trust.
- We saw 'Pause and Check' posters displayed in all imaging areas visited (The Society and College of Radiographers produced 'Pause and Check' resources to reduce the number of radiation incidents occurring within radiology departments). We also observed during a morning briefing staff being reminded to use the pause and check process. For all examinations we observed, staff identified patients in line with the pause and check process. However, some staff in CT told us they did not have time to apply fully the pause and check process by asking patients questions about what examination they were expecting and checking clinical information. This was a risk as pause and check can help prevent incidents of the wrong patient being imaged or receiving the wrong examination. The same staff told us of a recent incident in CT where a patient received the wrong examination. This incident may have been prevented if staff had followed the departmental pause and check process.
- Interventional radiology, breast imaging and ultrasound had adopted the World Health Organization (WHO) surgical checklist. Staff in interventional radiology told us the use of the checklist had been audited for the three months prior to the inspection which showed 100% of procedures had had a completed checklist.
- Patient health records contained a designated front sheet to aid in the identification of any known risk. For example a current or previous infection, allergies or previous anaesthetic reaction.

Assessing and responding to patient risk – Diagnostic Imaging

- Lincoln County Hospital was supported by an 'in-house' radiation protection service. They provided the radiation protection advisor (RPA), radiation waste advisor (RWA), medical physics expert (MPE), for diagnostic imaging, nuclear medicine, and provided support for lasers and magnet use within diagnostics throughout the trust.
- There were radiation protection supervisors (RPS) for each controlled radiation area. Their role met the Ionising Radiation Regulations 1999. We reviewed the radiology risk register. It included the IT issues related to the installation of the regional PACS as well as a number of items relating to imaging equipment.
- Patients were observed to ensure their safety during diagnostic procedures. Staff told us all patients who have an interventional procedure have a nurse escort from the ward. We saw CCTV in the viewing area in radiology to allow staff to monitor patient in the waiting areas
- Staff told us there was a policy for escalating significant findings to referrers quickly.
- We reviewed waste disposal and hand monitoring records in nuclear medicine. All were completed appropriately and were up to date.
- Magnetic resonance imaging (MRI) reports from scans carried out by third party providers were received by the department and required entering onto the computerised radiology information system. (RIS) Staff also told us they had to cut and paste the reports from the spreadsheet sent by the provider into RIS. This system could potentially result in transcription errors and patients receiving the wrong reports.

Nursing staffing

- There are no national standards for establishing safe nurse staffing levels in outpatient departments. A matron led the outpatient department supported by a band seven sister. Outpatient clinics were staffed by a combination of specialist and outpatient nurses.
- In the clinics we visited there was a trained nurse taking direct responsibility for the running of each clinic. In addition there was support provided by unqualified nursing staff. Outpatient staffing was planned in advance by the matron and clinic leads.

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- Data supplied by the trust on the use of bank and agency staff from April 2015 to March 2016 showed some clinics regularly used agency or bank staff, for example the pain clinic. At least one fifth of the pain clinic staff were temporary staff on five of the 12 months and there was only one month where no agency staff were used. Other clinics, for example the haematology clinic very rarely used temporary nursing staff and none had been used in 10 out of the same 12 month period.
- Staff we spoke with did not highlight any concerns about the staffing levels within the outpatient department. Medical staff raised a concern that there were a shortage of experienced clinical nurse specialist within some areas including diabetic care and rheumatology and staffing levels did not always enable a chaperone to easily found.
- From April 2015 to March 2016, Lincoln County Hospital reported a bank and agency usage rate of 3.72% in the outpatient department. During the same time period the average turnover rate at the in the outpatient department was 5.63%, the rate was based on two whole time equivalent staff leaving.

Medical staffing

- Medical staff were provided for outpatient clinics by the relevant business units in the trust.
- There are no national standards for establishing medical staffing requirements in outpatient departments. Nursing staff reported there were usually sufficient medical staff to run the clinics although during periods of leave or unexpected absence clinics did have to be cancelled.
- Medical staffing vacancies were contributing to the ability of the trust to meet the demand for appointments. Medical staffing vacancies were highlighted in several specialities including, general surgery, gastroenterology, cardiology, respiratory medicine and neurology. A combination of the inability to recruit to the vacant posts and agency costs being significantly in excess of the National Pricing Framework resulting in an inability to attract locums were identified by the trust Alternative options were being considered including funding additional nurse consultant posts.

Diagnostics staffing

- Cardiac diagnostic services were provided by a team of 11 specialist cardiac physiologists. A recent demand and

capacity review had identified the need for seven additional physiologists to meet the current workload demands. Locum staff were currently being employed both in the week and at weekends.

- These current cardiac physiologist staffing levels had been identified as unsafe and had been added to the trust's risk register in April 2015 and had been reviewed and remained a risk as of August 2016, however actions were being taken to mitigate this risk.
- Radiology management told us there were nine radiologist posts vacant. We were told recruiting radiologists to the area was an on-going challenge.
- Radiology management told us due to the difficulty in recruiting radiologists, they had to look at alternative arrangements for ensuring service was maintained. These arrangements included employing a radiologist from the Czech Republic who worked at the trust three weeks out of every four and sourcing specialist radiologist services, for example paediatric reporting, from nearby trusts.
- Radiology management told us there were no radiographer vacancies at Lincoln County Hospital. and to address shortages of radiographers they had recruited staff from Portugal. These radiographers had initially been employed as assistant practitioners whilst their professional registration was processed and once registration had been achieved they would be appointed as radiographers.
- Staff in ultrasound told us there were 1.4 whole time equivalent (WTE) sonographer vacancies.

Administration staffing

- An organisational development review had taken place, looking at the outpatient access, booking and choice teams to determine the staffing levels required to meet the current and anticipated future demands of the service. A reorganisation of administration team structure was imminently taking place following our inspection, with dedicated teams of health records management staff, appointment booking and clinic reception staff being implemented.

Major incident awareness and training

- There was a trust wide major incident plan in place to guide staff of all levels, and in all locations, as to what actions they needed to take in the event of a major incident being declared. This included establishing the outpatient services that could be cancelled.

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- Fire safety training was part of the trust's mandatory training. In clinic 6 a fire evacuation plan for the area was displayed.
- The senior staff in outpatient department had a good understanding of the role the department would take in response to a major incident. They were aware clinic appointments would be cancelled to enable the redeployment of staff to other areas of the hospital. They also identified clinics which would be used as triage or assessment areas for patients.
- We saw a major incident folder in the viewing area in A&E X-ray. All staff we spoke with in these areas were aware of this policy.

Are outpatient and diagnostic imaging services effective?

We did not rate the effectiveness of the outpatient and diagnostic imaging services. However, we found:

- Patient care was mostly delivered in line with evidenced based care and best practice guidelines. Staff had access to relevant trust policies and best practice guidelines to support them deliver good patient care.
- There was effective multidisciplinary working with staff, teams and services working together to deliver care and treatment to meet the patient's needs. Staff were suitably experienced and qualified and had the skills to deliver effective care.
- Specialist roles had been developed to ensure patients received expert care and advice from trained professionals when receiving new or difficult information about their health.
- Systems had been improved to monitor patient outcomes; this made information more readily available although the system relied on the quality and amount of inputted data.
- Radiography services were available 24 hours a day to meet urgent diagnostic needs across the trust, with senior radiology staff being available if required.
- Staff had a good understanding of the principles of obtaining patient consent to prior treatment and there was evidence to support this knowledge was applied appropriately in practice.

However, we also found

- There were delays in clinic letters being sent to GP and the patient following an appointment, some specialities had significant delays.
- Some staff within the radiology department did not have a good understanding of the practical application of the national diagnostic reference levels which had been established by the trust.
- Not all staff had received an annual appraisal as an opportunity to review practice and continue to develop in their role both personally and professionally.
- There were significant delays in the reporting of some diagnostic reports due to failures in the information technology systems used by the regional picture archiving and communication system (PACS).

Evidence-based care and treatment

- Staff had access to trust policies and procedures which were used to deliver care and treatment to patients in outpatient and diagnostic imaging. Staff in some clinics spoke of care being delivered in line with best practice guidance including the national institute for health and care excellence (NICE). For example the care delivered to patients experiencing macular degeneration who were cared for in the ophthalmology, clinic 6. Macular degeneration is a condition of the eye which affects the retina and reduces a person's vision. The pain clinic also used NICE guidelines when assessing planning and delivering care for patients experiencing back pain.
- The trust had established national diagnostic reference levels (DRLs) within radiology. Staff showed us the DRLs on the intranet however, the DRLs were not displayed in the imaging areas and most staff we spoke with did not appear to know how DRLs were to be used. DRLs are typical doses for examinations commonly performed in Radiology departments. They are set at a level so approximately 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses; however they can be used as a signpost to indicate to staff when equipment was not operating correctly.
- Policies and guidelines were available through the trust's intranet and staff told us they had opportunities to access computers to view these. However, on a couple of occasions when staff tried to show us documents on the intranet they could not easily locate them

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- We saw evidence that dose audits had been performed after the radiology department had installed digital X-ray equipment. The audits demonstrated the change in equipment had resulted in reductions in patient dose of approximately 25%.
- We viewed data from June 2016 which showed 64% of suspected stroke patients received brain imaging within an hour of admission and 91% within four hours of admission. NICE guidelines set out how quickly imaging should be performed for patients who are suspected of having had a stroke. The urgency of having a scan was dependent on patient symptoms.
- The e-outcome form was introduced at the hospital in March 2016. This enabled data on patient outcomes that had been completed on the data base to be auditable.
- In the outpatient physiotherapy department patient outcomes were monitored by a patient's own assessment on the impact of their treatment by patients conducting a self-assessment using a numerical scale before and after their period of treatment.
- Patients received specialist outpatient foot care services at Lincoln County Hospital podiatry clinic. The trust had participated in the national diabetic foot care audit. This audit monitored patient outcomes after 12 weeks of receiving their first specialist foot assessment. This enabled the trust to monitor patient outcomes and where appropriate benchmark these against the outcomes of patients receiving similar care in other hospitals.
- The trust provided details of the actions which had taken place in response to this audit, these included additional training for podiatrists to extend the scope of their role, three additional diabetic nurses had been recruited and since the summer of 2016 and a single referral pathway and portal had been in place for new foot clinic referrals.

Pain relief

- There was a designated clinic for the management of chronic pain. This clinic was part of the trust's pain management service.
- This was a consultant led service involving the wider multi-disciplinary team, including a clinical specialist nurse and physiotherapist. The service referred patients to primary care services if they needed the care of a clinical psychologist as part of their treatment.
- The royal college of anaesthetist's core standards for pain management services in the UK 2015. (CSPMS) identifies clinical psychologists as part of an interdisciplinary pain team. The college recommend the pain team should be staffed to conduct a full evaluation of a patient's physical and mental health with a clinical psychologist having dedicated sessions and contribute to multidisciplinary team meetings as part of the pain team.
- Staff we spoke of the positive impact a clinical psychologist in the team would have on patient care, including reducing the waiting time patients can currently experience. Staff informed us the trust had been unable to fund a clinical psychologist position within the team.
- Treatment provided by the service included physiotherapy, acupuncture and injections, care planning and delivery were based on the CSPMS guidelines.
- Simple pain relief was available if patients were in assessed as being in pain whilst they were in the clinics.

Patient outcomes

Competent staff

- New staff starting at the trust completed the trust induction which covered the aims and values of the trust and information on key policies on safety and training. In addition a local induction process provided information specific to the outpatient department.
- Clinical nurse specialists were employed within their speciality directorate with time rostered to manage outpatient clinics. Specialist nurses worked alongside, clinic nurses and also held specialist nurses led clinics. Nurse led clinics included those held in dermatology, diabetic care, ophthalmology, a tonsil clinic in the ear nose and throat department, a heart failure clinic in cardiology and a respiratory clinic.
- A clinical specialist nurse in the tonsillectomy clinic explained additional training had been provided to enable the nurses to discuss and obtain consent for surgery from patients whilst they were attending the clinic. Specialist nurses kept their knowledge current by working very closely with the consultants; one day every eight weeks was specifically rostered for this purpose.

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- The scope of the role of the clinical nurse specialists varied amongst the specialities, some were nurse prescribers where in other specialities this had not been included in the scope of their role.
- The matron in the out patients department had responsibility for staff appraisals. The trust target for appraisals was 95%. Data supplied by the trust as of July 2016, for Lincoln County Hospital and Pilgrim Hospital for the previous 12 months showed 71% of diagnostics staff and 83% of therapies staff had received an appraisal. This data did not include medical or dental staff at these sites.
- Most staff we spoke with had had a recent appraisal however; one staff member told us they had not had one within the last 12 months.
- Staff had access to their own electronic staff record which enabled them to book training, complete e learning and review their completed training courses or modules on their training matrix.
- In the outpatient physiotherapy department we observed a training session taking place. This was held by a senior member of staff and was well attended by the team. This was a planned session with no patient appointments being booked during this time enabling staff to focus on their learning.
- A qualified orthopaedic practitioner was part of the orthopaedic clinic team; this was a skilled position with staff being registered with the association of orthopaedic practitioners having completed specific training in the application of plaster casts. A second practitioner was currently being recruited and third was in training.
- Internal competency frameworks were used to access staff before they were able to carry out additional skills in their role. In the fracture clinic staff explained additional competencies were completed before using the plaster saws. We were provided with a copy of the trust wide plaster skills competency document which included the safe removal of casts by plaster saws and shears.
- Link nurses enabled clinic areas to keep up to date with key changes in practice for example in infection prevention and control, health and safety of chemicals, and safeguarding champions had just been introduced.
- Medical staff explained there were excellent training opportunities, with regular formal teaching sessions being held. Clinic nursing staff were supported to train to carry out additional skills for example obtaining blood samples.
- Registered nurses had been supported with the Nursing and Midwifery Council Revalidation process. Information had been provided by the trust and staff we asked had received support from within their departments. One nurse explained how the appraisal process was a good opportunity to highlight any personal training needs enabling staff to plan in advance for their revalidation.
- We saw evidence of role development for radiographers. Staff told us there were a number of radiographers reporting musculoskeletal X-rays and of plans to train radiographers to report chest X-rays. Radiology management told us a consultant sonographer performed injections to relieve musculoskeletal pain using ultrasound guidance.
- Staff explained the radiologists held regular discrepancy meetings to discuss radiology cases. However the reporting radiographers were not invited to attend these meetings. The reporting radiographers at Lincoln County Hospital held their own quarterly discrepancy meetings and any feedback from the radiologists was discussed at these meetings. Sonographers told us they hold monthly discrepancy meetings and staff were provided with feedback following the audits of reporting accuracy.
- We saw a spreadsheet which showed which scans each sonographer was competent to perform. Staff told us there was a good programme in place for training sonographers and there were six staff being trained at the time of the inspection.
- We saw completed and up-to-date training records for the interventional imaging equipment for both radiographers which included the medical staff who operated the equipment. We also saw completed training records for radiographers working in the X-ray department.

Multidisciplinary working

- Many clinics involved a significant contribution from several members of the multidisciplinary team. The teams included medical and nursing staff, physiotherapists and occupational therapists.

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Most clinics were led by consultant medical staff with support from medical staff from the speciality team.

- Staff spoke of their teams within each speciality area working well together. Multi-disciplinary team (MDT) meetings were held to ensure all members of the team were updated and included in discussions and development in the service. In dermatology staff explained monthly MDT meetings took place. Dermatologists held fortnightly MDT meetings with other associated specialities including the histopathologist, radiologist, oncologist, maxillofacial surgeons to discuss cases where skin cancer required treatment.
- The cardiologists held weekly regional MDT meetings with the cardiac surgeons in the east midlands region. Weekly MDT meetings were also held by the haematology team. diabetic consultants were joined by specialist nurses, dieticians and a biochemist in a weekly MDT meeting.
- We reviewed two haematology MDT meeting minutes these meeting had included patient case reviews and patient treatment plans were documented.
- Physiotherapists contributed to the care of patients in a wide range of out-patient specialities including the pain clinic and respiratory care.
- There was a phlebotomy service within the outpatient department working for all specialities as well as providing a service to patients referred by their GP.
- There were no joint diabetic foot clinics held with vascular surgeons or the availability of vascular ultrasound. Staff explained this was currently being discussed at this site and an emergency vascular review would be completed at the Pilgrim Hospital in Boston.
- Radiologists supported all multi-disciplinary team meetings (MDTs) that required their input.
- The consultant sonographer attended MDTs where appropriate and staff told us medical teams appreciate the sonographer's input at MDTs.
- Some radiographers told us they felt the radiologists could be more pro-active within the department. They also told us some of the radiologists supported radiographer role development. We saw very little interaction between the radiographers and radiologists during the inspection.

Seven-day services

- The majority of outpatient clinics were scheduled for Monday to Friday, there were no routine scheduled clinics held at a weekend.
- Saturday clinics were being held on a regular basis in a number of specialities including to reduce the length of time patients were waiting for their appointments. In dermatology Saturday clinics were being held to meet the two week referral time target for patients suspected of having cancer. Additional clinics were also being held in cardio physiology, rheumatology, neurology and diabetes.
- There were single consultant led transient ischaemic attack (TIA) clinics held every day Monday through to Saturday. A transient ischaemic attack is also known as a mini or temporary stroke and requires prompt investigation.
- The radiology service provided emergency cover 24 hours a day across CT, ultrasound, interventional radiology and cardiology as well as plain film imaging. Radiology management told us the radiologists on-call service, with both registrar and consultant grade radiologists available for any procedures requiring a radiologist out of hours. A radiologist was also available on site from 8am to 6pm at weekends. The trust also used a third party provider to authorise and report computed tomography (CT) studies from 6pm to 8am seven days a week.
- The CT department opened for booked appointments 8am to 6pm Monday to Friday. The magnetic resonance imaging department (MRI) provided appointments from 8am to 8pm seven days a week. Radiology management told us additional weekend and evening lists were offered for CT and ultrasound appointments; however, these lists were arranged on an ad hoc basis when waiting times for these scans start to increase

Access to information – Outpatients

- Staff were able to demonstrate how they accessed information on the trust's electronic system. Staff could locate trust policies and procedures relevant to their area of work, their own training records and live data on clinics being held.
- Following an outpatient appointment, a letter would be sent, usually electronically to the patient's GP. This provided an update on the clinic review and advised of any changes to treatment including medication.
- Following a consultation medical staff dictated the clinic letters on to either a tape machine or by using a digital

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dictation system. The timeframe within which letters were typed depended on the urgency of the letter. Urgent letters were completed within 48 hours and non-urgent within 10 working days.

- The digital system enabled staff from any of the trust sites to access the digital recording and if necessary type the letter. The digital system provided a record of which letters had been typed and which needed typing. Tapes limited who was able to type the letters as they would be located at one site within one team.
- There were 177 maxillofacial clinic letters waiting to be reviewed by a clinician so they could be sent out to the patients' GPs and the patients. These letters ranged from a variety of clinic dates, one we noted was from a clinic held on the 8th September 2016 which had been ready for signing since the 28th September 2016.
- In rheumatology we were told at the beginning of 2016 there had been a back log of clinic letters being sent out of up to five months after the appointment but this had now been reduced to six weeks. In dermatology secretaries were paid additional hours to ensure clinic letters were available.

Access to information – Diagnostic Imaging

- The trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patient's radiological images and records are stored securely and access was password protected.
- Staff told us and we saw evidence of a large backlog unreported examinations within radiology had led to long delays up to several months, to images receiving a radiology report. This backlog was caused because of information technology problems following the installation of a new regional PACS. We saw evidence, that systems were in place to monitor the time taken to report each examination and ensure urgent and high-risk examinations were reported as a priority. Radiology management also told us the trust had contracted two external reporting companies to assist with addressing the backlog.
- Patients told us appointment letters contained clear information.
- Staff told us and we observed daily morning briefings within radiology. These daily briefings provided staff with an opportunity to share information, raise any

concerns with colleagues as well as ensuring staff were aware of any incidents, changes to practice or problems within the department. These morning briefings were attended by radiographers, porters and clerical staff.

- Radiology management told us there was good communication between Lincoln County Hospital and the other sites within the trust and they made use of video conference facilities to reduce staff travel between sites for meetings.
- Staff within the breast-imaging department told us they held pan-trust meetings every three months. These meetings had a fixed agenda which included governance matters, complaints, incidents and any lessons learnt.
- Staff told us all ultrasound examinations were reported immediately after the examination. Reports for magnetic resonance imaging (MRI) examinations performed by third party providers are sometimes delayed in being sent to the trust, which required staff to "chase them".
- Radiology management told us information relating to research studies, including the target doses/dose limits, was available on the radiology section of the intranet. However, when we spoke with staff in CT they were not aware this information was available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtaining verbal consent from patients prior to delivering direct care.
- If written consent was required this was obtained by medical staff or by clinical nurse specialists who had received specific training as part of their advanced role. A patient confirmed the staff had sought their consent prior to a procedure being carried out.
- We reviewed four patient consent forms, they had all been completed correctly and signed.
- We observed staff seeking patients consent prior to delivering care, sufficient explanation was provided to enable patients to make an informed decision. Written consent was obtained for more complex procedures.
- Staff had sufficient understanding of the principles of the Mental Capacity Act, and had received training on the Mental Capacity Act as part of the trust's safeguarding training.
- One nurse recalled were a mental capacity assessment had been completed to ascertain if a patient had the capacity to give their consent.

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- During the inspection we observed a discussion between a patient with learning difficulties, the patient's carer and the staff. This conversation related to the consent for a blood test, this was handled very well by the staff and showed a good understanding and application of the Mental Capacity Act 2005.

Are outpatient and diagnostic imaging services caring?

Good



We rated the care provided to patients in outpatient and diagnostic services as good because patients were respected and treated with dignity, kindness and compassion.

- Staff respected patient's privacy and dignity and ensured consultations took place in a suitable environment.
- Patients were well informed about their condition and plans of care and staff took the time to explain important information to ensure patients understood what was being explained.
- Carers, relatives and friends were encouraged to accompany patients to the department and where appropriate with the consent of the patient, join them in the consultation.
- Staff understood the support patient's required when difficult information was being explained and this was planned to allow sufficient time and support to be available
- Patients were happy with the care they received and the NHS friends and family test data was the same as the England average for NHS trust providers.

Compassionate care

- Patients we spoke with felt the staff were caring in the way they delivered their care. They felt reassured and supported. We observed staff explaining information in a way patients understood. Patients commented that staff were caring professionals, friendly and informative and that they listened to what the patient said. One patient said the staff would have a joke and this helped to put them at their ease.
- We observed staff speaking with patients, they spoke in a kind manner, showed genuine concern and were

helpful and took time to listen even when the clinics were very busy. We observed staff taking the time to walk with patients and accompany them into the clinic areas.

- Reception staff were observed speaking to patients in a reassuring manner on the telephone, taking the time to explain and repeating information to ensure it was understood.
- Staff tried to ensure privacy was maintained during consultations, doors were closed and voices lowered to ensure other patients could not hear we observed staff knocking on doors and waiting to be asked to enter.
- Patients who had limited mobility were shown understanding and patience when they moving between different areas of the clinics. Assistance was offered whilst respecting the patient's wishes to be independent and walk rather than being wheeled in a chair.
- Staff in the haematology clinic were concerned they were not always able to offer patients the privacy they deserved whilst they had their observations recorded. Due to the lack of space in the clinic, the majority of the time patients had their observations taken in a room which was also used as a base for nursing staff, where clinic phone calls were received and where clinic notes were located.
- We did not see any patient observations being taken in this room during the inspection, but the room was set up as an office area with two desks and computers, a chair in the corner of the room was where patients sat to have their observations taken.
- The clinic had not received any negative patient feedback regarding their concern.
- We reviewed the NHS friends and family test (FFT) results for outpatient services for the previous three months. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Results from this reporting period showed 93% of respondents would recommend the NHS service they had received to friends and family who may need similar treatment or care. This was the same as the England average.

Understanding and involvement of patients and those close to them

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- Families and carers were welcomed into consultations to enable them to be informed and involved in the patients care and to provide support for the patient.
- Information made available to patients on the internet prior to them attending for their appointment for example for breast screening appointments encouraged patients to have a friend or family member accompany them to the appointment.
- Reception staff understood patients and relatives had personal commitments and we saw appointments made on specific days or times to accommodate work or family commitments.
- Patients we spoke with after their clinic appointment felt they had a good understanding of their care. Patients had received copies of the letters sent to their GP informing them of the outcome of previous clinic appointments.
- Staff understood clinic delays needed to be relayed to patients as soon as possible and we observed staff announcing the length of anticipated delays. This information was delivered clearly.
- We observed a consultant explaining the choices a patient had regarding the next stages of their care, the patient was provided with information to enable them to make an informed decision.

Emotional support

- Staff spoke of understanding the need to provide support for patients who were receiving difficult or complex information. Clinical nurse specialists provided specialist nursing advice during and after outpatient consultations. This helped alleviate the anxiety and distress a patient may feel when being given new, distressing or complex information.
- Staff explained they would know in advance if a patient was to receive bad news during an appointment. This enabled sufficient time and staff to be available to provide support patients.
- Staff understood the need to give patients sufficient time and a private room was available to ensure adequate privacy for patients. Additional support was also available from the specialist Macmillan cancer support service which was based within the hospital.
- The chaplaincy service was available to support patients and their families throughout the hospital. The service provided pastoral, religious and spiritual care

- Specialist counselling support was available for patients who were attending the hospitals breast care department; this was delivered at the Pilgrim Hospital site.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated the responsiveness of the outpatient and diagnostic services as requires improvement because services were not delivered in a way that met people's needs.

- Patients had been unable to access services in a timely way for an initial assessment, diagnosis or treatment including when cancer was suspected. During 2016 the trust has failed to meet the majority of the national standards for the cancer referral to treatment targets. This included the referral standard for patients suspected of cancer who needed to be seen with two weeks. This standard had not been consistently met during 2016.
- The trust had failed to meet the national standard for the referral to treatment time for incomplete pathways for the previous three consecutive months.
- There are significant delays in patients receiving their follow up outpatient appointment across several specialities with 3,772 appointments being overdue by more than six weeks. These did not include the patients identified as missing from the waiting lists.
- Some clinic areas did not meet the needs of patients, due to small waiting areas, limited consultation rooms and rooms which had insufficient soundproofing.
- Some services were planned to meet patient's individual needs however the offer of routine evening or weekend clinics was limited to radiology, making access to some outpatient specialties difficult for some patients
- There had been significant delays in the reporting of diagnostic imaging results due to technical difficulties.

However, we also found

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- Services were planned to meet patients urgent needs, rapid access clinics were available including for patients following an acute episode of chest pain or following an eye injury.
- Comprehensive information was provided for patients within the clinic areas including specific information on illness and treatment as well as general clinic information on visiting the department.
- One stop clinics were provided in some specialities for patients requiring prompt diagnosis and treatment.
- The trust did not attend rates were better than the England average and the utilisation of clinic slots was improving
- There was a documented complaints investigation process, a patient advice and liaison service was available and there was evidence to show the department made improvements from patient feedback.

Service planning and delivery to meet the needs of local people

- Although the outpatient departments were signposted from the main hospital reception we saw patients waiting in a queue to ask at the main hospital entrance reception desk to be directed to outpatient departments. Clinics were located on two floors with the majority being on the third floor. An outpatient reception desk was located on the third floor. The reception desk was not marked on the on line hospital map for this floor.
- The pain clinic was difficult to find, it was not located where the directions within the hospital indicated it was located. Patients attending the clinic would by nature of their symptoms need to locate the pain clinic without undue delay. Patients attending for their first appointment were not aware there was an alternative car park closer to the department than the main hospital car park.
- All patients we spoke with had received a letter prior for their appointment with sufficient information to enable them to attend their appointment on the correct day and time. Information included the location of the hospital and relevant information about parking.
- There was a regular public bus service to the hospital and bus timetables were displayed within the department.
- All patients we asked had been able to park, although there was a significant distance between the main car parks and the outpatient clinic areas. Blue badge holders had designated parking areas. We noted these where available outside the physiotherapy department; however the parking meters were not adjacent to the marked parking spots.
- Refreshments were available to purchase from outlets located adjacent to the outpatient and main reception areas. There were cool water dispenses within the department.
- There were patient self-check in facilities near the outpatient reception and in clinic areas. In clinic seven, several different services were delivered from the clinic. Some of these services used the self-check in system but others didn't.
- Patients who used the self-check in facility seemed to do so with reasonable ease, other patients and relatives we spoke with had used the facility to register when they had arrived at the clinic.
- During the inspection clinic the waiting areas appeared to cater for the numbers of patients visiting the clinics. One area was noted to have a small waiting area compared to the number of patients was the haematology clinic. The waiting area also covered patients waiting to have blood taken. Patients and relatives were seen standing and sitting in a cramped waiting room and in a corridor.
- Staff in this clinic area explained the clinic was very busy on most days with some days being particularly busy. One of the busier days in the haematology clinic was also the same day another weekly clinic was held in another clinical speciality where a significant number patients would require blood tests.
- Pagers were not available in the outpatient clinics this meant patients could not leave the clinic areas while waiting for their appointment.
- The trust delivered some outpatient services in the more rural areas of the county to prevent residents having to travel to the Lincoln County Hospital site. For example rheumatology services based at Lincoln also held clinics at Skegness, Grantham, Boston and Spalding. Oral and maxillofacial services were provided at Louth and Gainsborough as well as the main hospital sites in Lincoln and Boston.
- Services were planned to meet patient's urgent health needs. In the ophthalmology department a clinic was

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held to review urgent eye problems, these could be referred from a GP or via the emergency department. A designated phone line was used to enable prompt referrals to be made.

- There was a transient ischaemic attack (TIA) clinic held every day Monday through to Saturday. A transient ischaemic attack is also known as a mini of temporary stroke. This clinic enabled patients to be reviewed within a short timeframe of them becoming unwell therefore investigations and treatment could be commenced. Cardiology nurse practitioners held rapid access chest pain clinics, where patients who had recently experienced chest pains were reviewed, investigations conducted and potentially serious conditions diagnosed.
- Care was planned to reduce the number of visits a patient needed to attend before obtaining a diagnosis and commencing treatment. For example where possible investigations were carried out at the time of the first clinic visit. Specialities where this took place included dermatology, breast care services and medical patients who attended outpatients with suspected cancer of the lung who were able to have a CT scan at their first clinic appointment.
- Patients attending the fracture clinic who required an x ray at their next clinic visit had their x ray booked in advance to ensure their next visit went smoothly.
- Patients were not offered the opportunity to be looked after by another consultant to enable them to be seen within their planned appointment timeframe. Once a patient received care from a consultant they continued under that consultants care and waited for an outpatient appointment to be available. Senior staff responsible for managing the booking of clinic appointments explained consultants within the same speciality did not transfer patient care between each other. In some cases this was because treatment was very specialised.
- Consultant leave was managed to ensure sufficient notice was provided preventing clinics being cancelled at short notice. Staff in medical outpatients stated late notice cancellations only happened due to unavoidable circumstances.
- As part of the outpatient transformation programme and the introduction patient self-check in terminals not all clinic reception areas had a receptionist. A large number of staff from all areas of the outpatient department, including senior medical staff, nursing staff

and administration staff gave negative feedback about clinic reception areas not having a receptionist. Some clinics had had the reception staff taken away and had put a case forward for having a receptionist and they had been reinstated. In areas where this had happened staff were unsure whether reception staff would be staying in the clinic areas permanently.

- Some clinics had reception staff some days but not every day. Staff explained the negative impact this had had on patients; no one met patients when they arrived at clinic so patients were unsure whether they are at the right place, some clinic notes remained unavailable as reception staff would have previously helped to locate missing notes or letters. Nursing staff reported while they were busy in clinics, chaperoning during examinations it was difficult to leave this area to help patients who were in the waiting room.
- The central outpatient reception provided a point of contact for patients visiting the department on the third level but not all patients we saw visiting the department realised the desk was there or knew whether they should report to it. Staff spoke of clinic receptionists previously being part of the clinic team, working within the same clinic all the time and having a good understanding of the specialisms within in the clinic. Where appointments were required within six weeks of the consultation clinic reception staff booked the clinic appointment would have booked the appointment in the clinic. Some staff felt the receptionists knowledge helped ensure the patients were booked onto the right clinic.
- Our observations of clinic six where there was no receptionist on the day of our inspection were patient needs were not being met. Patients were anxious whether they were at the right clinic, unsure whether they should have reported to the main outpatient reception or whether they needed to use the self-check in machine. Some information was displayed about the services being provided but not having a receptionist appeared to be impacting negatively on patient needs being met. A member of the inspection team supported several patients on their arrival to the department whilst in the waiting area conducting observations.
- We observed a clinic area where a receptionist was based in the clinic. They provided support for patients, explaining what they needed to do, where to sit and who would call them for their appointment. The receptionist was observed providing information about

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the hospitals patient advice and liaison service for a patient who wished to discuss their care. They took notes to the health records department and were booking patient follow up appointments.

- Radiology departments had extended the working hours, to include weekends for some examinations to meet the demand for imaging services. Computed tomography (CT) services had extended the times the department was open to 8am to 8pm Monday to Friday. Magnetic resonance imaging (MRI) provided appointments from 7.30am to 8.30pm seven days a week.
- The trust used an external company to provide additional MRI capacity under contract as required. The trust also had a contract with a local independent hospital to provide scan appointments for a set number of patients each month. Radiology management told us they had out-sourced some of the radiology reporting in order to address the backlog of unreported images caused because of IT problems following the installation of a new PACS.
- Radiology management told us they actively tried to recruit student radiographers (on condition of qualification) based at Lincoln County Hospital six months prior to graduation to ensure radiographer-staffing levels were maintained. They told us this was “the best thing they had ever done”.

Access and flow

- A significant number of people did not have timely access to an initial assessment of their condition or timely access to follow up appointments for on-going care or treatment across a number of specialties. Processes were in place to ensure the most urgent and time critical patients received timely appointments. Where there is a delay in patients attending their first or follow up outpatient appointment there is a potential risk to patient safety, due to potential deterioration, but the systems in place helped to reduce this risk.
- There is a requirement for trusts to know how long patients are waiting for their outpatient appointments and to manage the services they provide to ensure patients waiting for and receiving care are safe. The time patients wait from a referral by their GP or other health care professional until a patient receives their first definitive treatment is known as the referral to treatment time.

- The trust’s referral to treatment time (RTT) for non – admitted pathways had been worse than the England overall performance for the period July 2015 to September 2016. There is no national operational performance standard for this data however, CQC monitor this data as part of their assessment of timely access to care and treatment for patients. A non-admitted pathway is when a patient’s wait for their treatment has ended and they have commenced consultant led treatment without being admitted to hospital to receive the treatment.
- At the end of August 2016, there were 2946 patients waiting over 18 weeks on an incomplete pathway, 2033 of these patients were on non-admitted pathways. The trust explained there was an extra 985 patients waiting over 18 weeks at the end of August 2016 compared to the end of May 2016. The trust had received 1,400 more appointment requests than in the previous 12 months, this increasing demand and back log of follow up appointments were impacting on the ability of the trust to provide appointments for new referrals.
- On the week of the inspection the trust provided data on the number of patients who were waiting for a follow up appointments, 7,483 patients were on the waiting list. Of these 3,772 patients were overdue their scheduled appointment date by more than six weeks.
- The trust’s overall referral to treatment time (RTT) performance for incomplete pathways for outpatients had met the national standard from April to June 2016. The national standard is 92%. In July the trust achieved 91% this fell to 89% in August and to 88% in September 2016. An incomplete pathway is when a patient has been referred for treatment but at the time the data was collected they had not yet commenced the treatment.
- The incomplete pathway operational standard is the measure of patients’ constitutional right to start treatment within 18 weeks. No one should wait longer than 52 weeks for treatment. The trust reported during the week of the inspection five patients had been waiting 52 weeks or more for their appointment.
- There are national waiting time standards to ensure cancer services are delivered to patients in a timely and safe timeframe. From January 2016 to September 2016 the trust met between one and five of the national standards for cancer targets each month. There had been no months during 2016 where the trust met all the national cancer referral to treatment standards.

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- The national standard for patients who are referred with suspected cancer or who have breast symptoms is for 93% of patients to be seen within two weeks of being referred. From data reported April to August 2016 the trust had not met this standard, with 81.12% being their lowest performance reported in August. During this month the standard was not met in eight specialities. However September and October 2016 this standard had been met, however even in these months some specialities did not meet the 93% standard.
- During August 2016 the trust only met the two week referral standard for 31% of the patients referred with suspected breast cancer and for 26.3% of the patients referred with breast symptoms. This was a significant reduction from previous month where it had achieved the 93% standard. The trust had taken immediate actions to address these delays and in September 2016 both these referral to treatment times for suspected and symptomatic breast referrals had significantly improved to 91.5% and 88.8%. This was the result of capacity deficits within the Radiology Services and was a significant reduction from previous month where it had achieved the 93% standard. The trust along with health system partners acted proactively to address the issues and in September 2016 both the referral to assessment times for suspected and symptomatic breast referrals had significantly improved to 91.5% and 88.8%.
- Patients had timely access to diagnostic services; however there had been significant delays in some patients receiving their investigation results. Between July 2015 and June 2016 the percentage of patients waiting more than six weeks for a diagnostic test was lower than the England average. A diagnostic test was a test or procedure to identify a patient's disease or condition to allow a medical diagnosis to be made, for example an ultra sound scan. As of July 2016, 7,288 patients had been referred and were waiting for a diagnostic test, 79 of these patients (1.1%) had been waiting longer than six weeks.
- Staff told us and we saw evidence that the average waiting time for an ultrasound scan was three to four weeks. However staff also told us all patients suspected of having cancer were scanned within two weeks. We saw evidence that waiting times for a DXA scan was three weeks. DXA scans are examinations that assess bone mineral density and assess the risk of bone fractures.
- Staff told us and we saw evidence of a large backlog unreported examinations within radiology had led to long delays (in some cases of several months) to images receiving a radiology report. Radiology management told us, and we saw evidence, that systems were in place to monitor the time taken to report each examination and ensure urgent and high-risk examinations were reported as a priority.
- Radiology management told us, all X-ray examinations with the exception of chest and abdomen X-rays were reported within a week. We observed staff being told the reporting time for referrals from GPs for chest and abdomen X-rays was three to four weeks.
- Actions taken by the trust to minimise the time patients waited for treatment included holding additional clinics and holding virtual clinics. These were when medical staff reviewed the patient's notes and investigation results without the patient attending the outpatient department. Virtual clinics were taking place in several specialities, including dermatology, cardiology and urology. Patients and their GP were informed of the outcome of their review and the need to attend further appointments by letter.
- Vacant clinic slots were actively managed to help minimise waiting times by making best use of the available clinics. Clinic utilisation had been identified as one of the work streams within the outpatient transformation programme. We reviewed the meeting minutes from an ophthalmology governance meeting from March 2016 which reported vacant clinic slots had been reduced from an average of 100 a week to between 30 and 60.
- Staff explained over booking did occur but this was happening to a lesser degree than previously in some clinic areas, staff stated they realised it was difficult when patients needed to be seen urgently.
- The appointment system was accessible to both patients and health care professionals. The majority of new outpatient appointments were booked via the NHS e-referral service. This was an on line booking portal that could be accessed by both GPs and patients. This system provided the referrer or patient with information on the availability of appointments.
- Follow up appointments were managed via a partial booking waiting list (PBWL) system. This was where patients requiring a follow up appointment within six

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weeks of their current clinic appointment would receive an appointment before they left the hospital. If a follow up appointment was required after this date then patients were sent an appointment through the post.

- Telephone calls made to the trust to book, amend or cancel appointments were managed by the choice and access department. From February to July 2016 an average of 7,570 calls were made to this department per month with an average of 93% being answered.
- Additional clinics to meet the high demand for appointments were held at weekends however there were no scheduled evening or weekend clinics.
- Urgent referrals for example those where cancer was suspected were identified by the referring GP as requiring an appointment within two weeks of the referral. These appointments were then given highest priority when clinics slots were allocated. A proportion of clinic slots were pre-allocated for urgent referrals so these would be available for urgent referrals received within a few days of the clinic date.
- Clinics were cancelled when there was insufficient staff to hold the clinic. Cancellations had to be authorised by a senior business unit manager. Data supplied by the trust for April to July 2016, showed of the 41,472 scheduled clinics sessions across all sites 1,387 (3.3%) were cancelled within six weeks of the clinic date. Of these 32.5% were due to consultant annual leave. At Lincoln County Hospital of the 18,622 outpatient clinic sessions 690 (3.7%) had been cancelled within six weeks of the clinic date. Patients were informed by letter of clinic cancellations.
- From February to July 2016 the trust reported waiting times for outpatient and diagnostic test appointments, once patients had arrived at clinic of between 24 minutes at the haematology clinic and being seen within the first minute of arrival at the clinical neurophysiology department. This speciality service investigates and diagnoses disorders of the nervous system. Trust data from April to September 2016 reported at Lincoln outpatient department 13.8% of patients waited longer than 30 minutes from arrival at the department to being seen in clinic. We did not observe any long clinic delays during the inspection.
- The trust monitored and managed the patients that didn't attend for their scheduled appointment. The number of patients that did not attend (DNA) for their appointments was lower than the England average DNA rate.

- The trust's policy when patients did not attend for their appointment was part of their patient access policy. In line with this policy where patients had not attended for their appointment the consultant reviewed their records and a decision was made regarding further appointments. We spoke with staff about the DNA procedure and they confirmed it was managed in line with the trust policy.
- If a decision was made not to offer a patient another appointment then a letter was sent to the patients GP and the patient informing them of and the reason why this decision had been made. Patients could be re referred by their GP.
- We discussed the use of appointment reminders sent to patients via text message with a member of staff in the outpatient physiotherapy department. A trial had been conducted to establish if sending a text reminder had any impact on the attendance rate for appointments. The department had not seen any change to their attendance rate.

Meeting people's individual needs

- Patient's individual needs were discussed in two of the staff huddles we observed. Information was shared with staff regarding patients who were due to visit the clinic that day, who had specific personal needs. These included one where a patient may not be able to hear their name called, one patient who would be using a wheelchair and one patient who would need oxygen therapy during their visit. This enabled their care to be planned and needs met on their arrival and throughout their clinic appointment.
- Space within the main outpatient clinics was limited, staff in two clinics felt the reallocation of space had resulted in a negative impact on patient experience. In one clinic had the children's waiting area had been changed into an office space and another clinic had a room which could accommodate larger pieces of equipment for example a bariatric wheelchairs re allocated to another clinic.
- In the haematology clinic we observed the soundproofing between clinic rooms did not provide sufficient privacy for patients as conversations could be heard in adjacent rooms. Patients were also not provided with sufficient privacy during blood test examinations, where only a curtain divided two patient areas and patients could be seen by other patients and staff moving between clinic rooms.

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- Staff had not received any specific training on caring for patients with learning disabilities or for patients living with dementia. Staff however did explain a private room would be made available if this was required, patients would be given additional time during their appointment and would be given the first clinic appointment whenever possible. In some clinics staff spoke of recognising patients who had regular appointments and knew when they needed additional help or additional time.
- Staff explained if prisoners visited the outpatient department the clinic would be informed in advance of an appointment to enable a private room to be provided whenever possible. During the inspection we did see a prisoner and two prison guards in the main waiting area waiting for an appointment in clinic 11.
- Clinics were held on a Saturday across many specialities as part of the recovery programme to address the number of patients waiting for follow up appointments on the PBWL. Saturday clinics were also used to see new patients who required an urgent review within two weeks of their referral date. There were no regular evening clinics scheduled.
- Information leaflets were available for patients to take away, these provided specific advice and education about the relevant speciality being held in the clinic. Information about relevant support groups was prominently displayed. The information leaflets were in English however alternative presentations for example in braille or larger type font were available. Literature could also be obtained in different languages.
- The main outpatient corridors could comfortably accommodate wheelchairs however some of the clinic areas were quite limited for space and trolleys stood in corridors making areas quite cramped. The main reception desk was wheelchair accessible and toilet facilities within the department were available and could accommodate a wheelchair. Other examples of where individual needs were met included baby changing facilities being provided and the screen on the self-check point in the ophthalmology department included black text on a yellow background to make it easier to see.
- Patients for non-urgent examinations within radiology were not given a choice as to when their appointment would be. We were told patients could phone to change their appointment times to accommodate patient needs. Staff also told us if they were aware a patient had learning disabilities they would book a longer appointment.
- We saw separate outpatient and in-patient waiting areas in radiology. The waiting area had some raised chairs for patients with mobility difficulties as well as seating suitable for bariatric patients. There was also a separate waiting area in the nuclear department for patients who had had a radio isotope injection. We saw patients had changed into hospital gowns waiting in a separate area to other patients; however, we could not see whether dressing gowns were also provided for patients.
- Staff in computed tomography (CT) and medical physics told us one of the two CT scanners used slightly lower doses for scanning patients.
- Staff in ultrasound told us there was always a helper available to act as a chaperone when required. In the x ray and breast imaging department we saw patient information leaflets in a 'reader-friendly' format. There was also information relating to parking charges displayed.
- In the urology investigation unit where up to twelve patients could be in the department at any one time undergoing investigation relating to urinary system there was one toilet. This was used by both male and female patients. We asked staff about the toilet facilities and they were not aware of any patients raising concerns about the toilet facilities in the department.
- Information was provided in several different languages throughout the department. Interpretation services were available and staff knew how to arrange for these to be made available. During the inspection an interpreter had assisted during a face to face consultation. Staff explained language line was also used.
- The trust had committed to improving the accessibility of the building and had joined a third party charitable organisation to ensure accurate accessibility arrangements would be made available via their website. A nurse from the ophthalmology clinic was involved in this trust wide improvement programme.

Learning from complaints and concerns

- Clinics displayed clear information on how to complain or provide positive feedback to the trust. The trust website gave information on how to complain and where complaints should be sent to.

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- A patient advice and liaison service (Pals) was based in the main reception to the hospital and was available to provide support and information to patients. The service was also contactable via email, social media and text.
- The trust planned complaint response times were on the trust website; this included an initial acknowledgement response within three working days, a phone call from a senior member of staff to agree response timeframes and patient expectations. A single point of contact was provided for the patient. Contact details were provided for the health service ombudsman and for a free independent patient advocacy service.
- We reviewed outpatient department staff meeting minutes which confirmed complaints were a standard item agenda each month. These minutes were made available to staff in the clinic areas both in hard copy and via email.
- From June 2016 complaints across the trust were peer reviewed by a group with patient and external representatives. This ensured the complaints process had been followed. This had become a lessons learned forum from July 2016 with trust wide membership and ensured learning was shared. The trust was also working with London School of Economics on a research project on learning from complaints.
- Staff spoke of dealing with patient concerns as they arose particularly in relation to waiting times.
- From June 2015 to May 2016 there had been 17 complaints received by the outpatient department at this hospital site. The most common areas for complaint related to waiting times, communication and department facilities.
- Concerns raised with the suitability of seating in the ENT clinic had been addressed, new chairs had been provided and a new layout to ensure all patients were facing the main clinic area so they could hear or see the clinic staff.
- Patient feedback regarding car parking charges had led to the trust providing additional information for patients. We saw information displayed in the clinic waiting areas which explained the car parking charges and the reductions available for patients.
- Radiology management explained the patient advice and liaison service (PALS) forwarded complaints to the

radiology department. All staff we spoke with regarding complaints explained if a verbal complaint was made to them they would discuss the issues with the complainant at the time to try to address the situation.

- Complaints, incidents and learning from incident investigations were discussed at regular radiology clinical governance meetings.
- We observed a morning briefing where staff were updated on the friends and family test results, this included positive comments from patients that radiology provided a fast and excellent service and staff were knowledgeable. Negative comments included, patients would like subtitles on the television in the waiting room for patients who are hard of hearing and instructions for patients who are required to change on how to put on the gowns would be appreciated.

Are outpatient and diagnostic imaging services well-led?

Inadequate



We rated the leadership of the outpatient and diagnostic services as inadequate because leadership of the service did not always support the delivery of high quality and responsive care.

- The outpatient service had a dedicated strategy. However, it was not underpinned by realistic objectives and plans. Actions to address key issues in meeting organisational targets were overdue or had not been achieved. We saw the hospital had some of the same identified issues we found during our 2014 and 2015 inspections.
- The outpatient transformation programme had identified several key risks and issues affecting patients and outpatient services. Some of the risks were long standing and had not been addressed despite the transformation programme.
- Senior clinical staff were aware of the key risks within their own areas, these included waiting times, patient record availability and environmental challenges. The outpatient transformation lead was the only manager we spoke with who had knowledge about strategic risks

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across the whole of outpatient services. The outpatient transformation programme provided reports and escalated risks to business units and the Operations meeting.

- Governance arrangements and accountabilities for managing performance were unclear. Different business units and departments were accountable and responsible for different elements of outpatient functions and performance. There was no single accountable manager or person responsible for the performance of outpatient services.
- There were governance and risk management processes in place. These included regular outpatient capacity meetings and weekly operational performance committee meetings. Although these processes were in place there was not always timely actions taken to address ineffective performance or increasing demand for services.
- Measures to tackle key risks and performance were ineffective. There had been a lack of oversight of some key risks affecting care and treatment. Significant issues which threatened the delivery of safe, effective, and responsive care were either not identified in a timely manner. Adequate action to manage them was not always taken. For example, actions to deal with the number of patients waiting for appointments and without recorded outcomes did not meet identified timeframes.
- The trust reported there had been an on-going process of engagement with staff throughout the formal patient administration review process. However in some departments there were low levels of staff satisfaction. Some staff did not feel managers had sufficiently informed, engaged or included them in the changes the trust made to their roles or to other staff roles within the clinics. This had a negative impact on staff morale.
- The outpatient transformation lead was the only manager who had full knowledge of the risks and issues facing outpatient services. This was a temporary role meaning there was a risk this knowledge could be lost.

However, we also found

- A new management structure was in place, outpatient services had transferred into the clinical support services business unit and the trust had appointed a new business manager. A live dashboard provided data on the services performance.

- The outpatient transformation programme introduced a phased introduction of clinic standards, staff felt engaged with and motivated by this process.
- Outpatient department nursing leads were visible and provided both practical and professional support for clinic staff.
- There were examples of effective public engagement, with public representation on the outpatient transformation committee and the trust had commissioned a review of the service by Healthwatch.

Vision and strategy for this service

- The outpatient service had a documented strategy for improving services throughout the trust covering the period 2016 to 2021. The strategy built on changes that had taken place during 2015 as part of an outpatient improvement programme. This document identified key areas for improvement including, the utilisation of clinic space and scheduled clinic time and addressing the inconsistency across the booking system, which contributed to high did not attend (DNA) rates. The content, availability and condition of health records led to cancellation of appointments and poor patient experience. The number of delayed or missing clinic outcomes resulting in loss of trust income.
- The trust had established a three phased outpatient transformation programme for April 2016 to March 2021. This had followed on from a previous outpatient improvement programme, which had been in place over 2015 and 2016. At the time of the inspection, the trust was in phase two. The transformation programme contained five key project areas. These were the outpatient environment, the workforce, the management of follow up patients, systems and processes for example the introduction of e outcomes and clinic standards and the utilisation of clinics including capacity for and the scheduling of appointments. In April 2016, the priorities and co-dependency of these projects were determined and key milestones and key performance indicators were established.
- Phase one of the transformation programme was complete. In July 2016, the outpatient department and the access booking and choice team had moved into the clinical support services business unit. There was now a single management team who were responsible for outpatient services. The individual business units still held responsibility for management of patients who

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required outpatient care. Depending on whether a business unit was responsible for services across all hospital sites or just at one site determined the number of business units involved in each speciality.

- However the Trust has been largely ineffective in meeting the organisational targets to have no patient overdue for their follow up outpatient appointment by more than six weeks by March 2016. The trust had also not met the revised target of September 2016. At the end of August 2016, the trust reported 2,033 patients had been waiting over 18 weeks for their first definitive treatment whilst on an outpatient pathway. Capacity constraints were affecting their ability to make faster progress.
- A workforce review had commenced focused on the administration staff working in the health records, reception and access booking and choice teams across the trust. There were also plans to alter the line management of the outpatient matrons to bring them under the clinical services management. They would retain the head of nursing as their clinical lead.
- Outpatient departments displayed the trust vision and values in clinic areas, staff spoke of the local improvements that had been made in their areas as part of the transformation programme. There had been some environment changes, and staff spoke positively about the introduction of clinic standards. Departments had standardised clinic rooms and processes for setting up and finishing clinic sessions.
- Radiology management told us, due to the difficulty in recruiting radiologists, they had to look at alternative arrangements for ensuring service was maintained. These arrangements included employing a radiologist from the Czech Republic who worked at the trust three weeks out of every four and sourcing specialist radiologist services, for example paediatric reporting, from nearby trusts. Staff in DXA scan department expressed concerns regarding a potential restructuring of the service. A DXA scan is a special type of X-ray, which measures bone mineral density.
- The outpatient and diagnostic imaging structure was in a state of transition at the time of our inspection. This was because outpatient services had recently moved to the clinical support business unit. The clinical director said he had only been responsible for outpatient services for a few months at the time of our inspection. Since our last inspection, managers said there had been several managers responsible for the delivery of outpatient services. Therefore, senior managers in the business unit were still in the process of gaining a full understanding of how the services all worked.
- At the time of our inspection, the business unit was introducing a new management structure for administrative and nursing staff as part of a workforce review. Therefore, some management roles were temporary or new for some managers. Transition engagement sessions were held with key managers to outline the new roles and responsibilities. Some staff advised the investigation team that this led to some staff uncertainty, particularly for the administrative staff in relation to responsibility and accountability. The aim of the restructure was to provide more accountability for outpatient services, including the back office functions
- A key aspect of managing the risk of new patient referrals was ensuring a suitably experienced clinician reviewed and graded referrals received to establish timeframes within which they needed to see the patient. This enabled staff to attach the correct degree of urgency to the appointment request. However, we saw the review and grading of new referrals was not always timely.
- We were informed business units had a daily report on the number of patients waiting for a follow up appointment within their clinical specialities. The clinical support business unit provided a weekly analysis of the patients overdue by more than six weeks. The business unit shared the report with other managers at the beginning of every week. Staff placed alerts on patients they identified as requiring an appointment within a time critical (TC) period on the waiting list electronic database. The report from the week of the inspection identified 37 time critical patients were over due by more than six weeks of their appointment timescale.
- The outpatient transformation programme had identified several key risks and issues affecting patients and outpatient services. The outpatient transformation programme has its own risk log. Some of the risks were

Governance, risk management and quality measurement

- We had raised concerns about the outpatient service at this hospital at our 2014 and 2015 inspections. We found these issues had not been adequately addressed and the same issues were still being raised as a concern.

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long standing including health records and some not, for example patients incorrectly missing from the partial booking waiting list. The lead for the transformation programme had a good understanding of the risks and escalated concerns to business units, the executive team and various committees responsible for governance and performance. This demonstrated that the trust had acknowledged long standing risks but experienced difficulty in fully mitigating them.

- The majority of staff we spoke with knew about the key risks to their service included on the outpatients (log) and trust risk register. This included the quality and availability of patient records, overdue appointments and environmental challenges. However, the outpatient transformation lead was the only manager we spoke with who had knowledge about strategic risks across the whole of outpatient services. The outpatient transformation programme provided reports and escalated risks to business units and the Operations meeting.
- Business units held the responsibility for managing the potential risk to patients delayed beyond the scheduled timeframe for their clinic appointment. Weekly operational meetings held business units to account for the actions they were taking to manage this potential risk.
- We reviewed the meeting minutes from the previous two operational meetings, which showed communication had taken place with the commissioners and with third party providers to try to address the unmet outpatient demand. Business units responsible for their waiting lists had developed action plans to address the appointment backlog. Managers discussed action plans at the operational meetings. We saw progress varied between specialties.
- We reviewed the action plans for nine of business units which included actions for maximising clinic capacity and performance, reviewing patient risk, staff recruitment, the re location of clinics and managing demand. However, evidence in the the minutes of the twice weekly cross-site capacity meetings, and from our discussions with senior members of staff we established the business units were managing resources to try to meet both an increasing demand for outpatient services and address the significant number of overdue appointments. While some departments had made improvements in the number of overdue appointments

progress had not been as quick as expected. In addition, this had contributed to new patients waiting longer for their first appointment in several specialties and the trust had met only a third of cancer referral targets.

- Obtaining sufficient staff to run the additional clinics was a significant problem. Several specialties had struggled to recruit to consultant posts that had become vacant. Nursing staff had covered additional clinics over an extended period and the trust were now struggling to staff the additional clinics despite offering overtime. Where staffing was in place, an insufficient amount of physical space to hold the additional clinics at sites throughout the trust or on third party premises had prevented some specialties holding additional clinics.
- During 2016 the trust identified the computerised records may not accurately reflect the number of patients who were actually waiting for treatment. This issue had been initially identified in May 2016 discovered and possibly affected patients going back two years and had been caused by poor management of the electronic patient administration system. We saw from minutes of the operational performance board (October 2016) discussion regarding large numbers of patients potentially waiting for treatment who were not on the electronic waiting list. The trust had started a validation exercise to determine the extent of the problem and actual numbers.
- We spoke to staff providing data validation services to the trust as part of a wider team of 20 staff. They said they had identified patients who had been missing from the PBWL. This posed a risk to patient safety
- At our previous inspection, CQC highlighted the lack of quality of patient medical records. We saw on our inspection that this remained a key concern for staff. The quality and size of records affected staff accessing the most appropriate information for patients. Staff said nothing had improved since our last inspection. An escalation report from the clinical records committee (October 2016), to the information governance committee highlighted longstanding issues with the quality, availability, and filing of patient records. This report highlighted the trust had the same issues and in some cases the present situation was worse demonstrating a lack of progress.
- Following the inspection the trust provided us with a typing recovery plan outlining the action taken to resolve the backlog of clinic letters. Actions included

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recruiting agency staff, moving staff to work in the busier areas and staff working overtime. The recovery plan dated back to 2014, which demonstrated typing delays were a long-standing issue and the trust was not always able to sustain any improvements made.

- We had previously raised concerns in our inspections in 2014 and 2015 regarding the condition and availability of medical records and the overbooking of clinics. In relation to clinic overbooking, it was noted that there had been some improvement but this was limited by capacity and the prioritisation of urgent appointments

Leadership of service

- There had been a quite recent change in the senior leadership of outpatient services, with all aspects of the service moving under the clinical services business unit and a senior business manager coming into post in July 2016.
- Senior nursing staff provided visible leadership to the outpatient department and staff spoke of feeling supported and having an approachable leader.
- Senior nursing staff were visible within the departments and had a clear understanding of the day to day challenges the department faced and were actively involved in the current transformation programme. There were clear and established methods of communication between senior nursing staff and the clinic teams.
- There was cross-site communication between senior staff, this was not always face to face but was structured and staff recorded meeting minutes.
- Staff had differing views on whether the trust's senior executive team knew the challenges facing outpatient services and how these differed within each speciality. Staff explained the outpatient transformation programme had been positive for the service. It had given them more involvement and a voice within the trust.
- Within the clinics, staff said senior staff supported them. We observed senior radiographers praising individual staff members during a morning briefing.

Culture within the service

- Most of the staff we spoke with explained there was good team working, with staff being flexible and supporting each. Many staff had worked in outpatients a number of years. Clinic teams and staff in the radiology department were observed working well together and

appeared motivated and passionate and proud about their work. Radiology staff told us they were proud of "how hard everyone works" and the team "help each other out."

- However some staff felt under pressure by the demand of the work load. Recent and forthcoming changes to the structure of the service had led to anxiety and uncertainty for some staff groups and this had impacted negatively on staff morale.
- Administration staff were in the process of moving to into new team structures and some staff felt there had been poor communication and little consultation regarding the structural changes which were taking place. Evidence was shared with the inspectors which confirmed that engagement sessions were held with key managers to outline the new roles and responsibilities.
- Nursing staff spoke of being encouraged to report incidents and felt there was support from more senior staff and managers. Administration staff did not feel there was the same degree of support or openness.
- Every radiographer we spoke with knew what 'duty of candour' was and all said they would be open and honest with a patient if something had gone wrong. We also saw screen-savers displayed on computer screens reminded staff about duty of candour.
- Radiographers told us the daily team briefings were great and had resulted in staff talking to each other more and sharing information.
- All the staff working within the diagnostic services explained they liked working at the trust and some had worked there for a long time. .

Public engagement

- A patient representative was part of the outpatient transformation committee and feedback on programme activity was shared via a monthly patient representative member's newsletter.
- Patient feedback was sought via a variety of methods; information posters were displayed in clinic areas informing patients about the patient advice and liaison service and how to provide feedback to the trust. The department participated in the national survey of patient views on if they would recommend the service. Patient feedback was obtained via a text message sent after their clinic appointment.

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- Trust data from August 2016 reported 93% of patients would recommend outpatient services which was in line with the national average results and had been consistent throughout the previous six months.
- Thirty four patient views had been sought as part of a healthwatch review of the outpatient department in carried out in March 2016. This had been completed in response to the previous CQC inspection findings and at the request of the trust. The trust response to the Healthwatch review findings was publically available as part of the published report.
- The trust had recently published an internal report on their approach to meaningful public engagement which set out the trust's plans to improve their engagement process and their principles of public engagement.
- Staff in the DXA scan department told us they had held promotional events to publicise the service with local GPs. This had resulted in 70% of referrals received by the department being from GPs. A DXA scan is a special type of X-ray that measures bone mineral density.
- Public views were also obtained via on line feedback from independent and NHS on-line patient experience websites.

Staff engagement

- Staff engagement was variable across different staff groups within the outpatient department. Nursing staff spoke positively of being involved in the outpatient transformation programme and of being part of the new clinic standards.
- Most clinical staff had monthly team meetings which were minuted and provided relevant updates for staff on both department and wider trust information. Some team meetings were not carried out regularly or had been cancelled due to clinic commitments. Staff in the urology investigation unit had not attended any team meetings in recent months. Staff huddles at the start of the clinic day also provided an opportunity for the dissemination of information to the clinic staff.
- We spoke with administration staff that had only had four team meetings in the last 12 months and senior staff confirmed more team meetings were required.
- Nursing staff explained they saw senior staff every day and felt they were kept up to date. One senior member of medical staff felt engaged with the trust however, another explained their attempts to meet with senior

trust executives had been unsuccessful. One member of staff explained how changes had been made to the dispensing protocol for the trust without their involvement.

- Administration staff felt poorly informed about the changes that were taking place across the access choice booking and health records staff. Staff had spoken with by their manager however, some staff felt they were given little information and some were unable to attend meetings about the changes as they were not at work. We reviewed the meeting presentation material and meeting minutes which confirmed staff meetings were held for this specific purpose.
- The majority of clinic staff, both nursing and administration did not feel they had been involved in the decision to remove the clinic based reception staff to a more centralised outpatient desk. Some clinics had been persistent in pointing out the negative impact this decision had had on both patients and staff and in some clinics the position had been re-established.
- Staff were recognised and received rewards for their achievements. The outpatient department musculoskeletal trust wide team had won a customer service award in the staff awards. They had been presented with the chairman's great customer service award and this was displayed in the clinic area.
- Staff explained they had access to the chief executive on line messages and also received trust updates via email.
- Radiology management described their staff as "fantastic", hardworking and flexible and were proud of the quality of the service they provided and the level of expertise.
- Several staff members told us the problems the department had experienced with the PACS had had a negative impact on morale.

Innovation, improvement and sustainability

- A booking tool had been devised by a consultant to improve the on line booking process, this helped appointment staff to book patients onto the right clinic within the speciality of ophthalmics. The appointment booking team explained this was very useful however, it not been shared across other specialities. Senior trust staff were unaware of the tool which had been developed a year ago.
- Nursing staff in the ophthalmology clinic were trailing a new way of working. One member of staff carried out a

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coordinator role. This enabled them to support answer patient questions, source missing notes and assist with vision tests, leaving clinic staff to remain with patients throughout their appointment.

- The cardiology service was establishing a register of patients with abnormal heart valves with the intention of setting up a physiologist led clinic.
- The trust had committed to improving the accessibility of the building and had joined a third party charitable organisation to ensure accurate accessibility arrangements would be made available via their website. A nurse from the ophthalmology clinic was involved in this trust wide improvement programme.

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the hospital MUST take to improve

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

Outstanding practice and areas for improvement

- The trust must take action to ensure all staff working in the termination of pregnancy service receive formal counselling training.
- The trust must take action to ensure that the handover process on Nettleham ward does not compromise patient's privacy.
- The trust must take action to ensure that sensitive patient groups are not mixed within gynaecology and maternity outpatient areas.
- The trust must ensure the environment within clinic 6 is reviewed and actions taken to prevent or control the potential risk to patients from infections. The trust must comply with the Health and Social Care Act 2008, Code of Practice On the prevention and control of infections and related guidance.
- The trust must ensure that the drinking water dispensers are cleaned and maintained in accordance the manufacturer's instructions including completion of scheduled electrical safety testing, a water hygiene maintenance programme and cleaning schedule.
- The trust must ensure that equipment is appropriately maintained. Ensure any checks carried out by staff are recorded and done with sufficient frequency and with sufficient knowledge to minimise the risk of potential harm to patients.
- The trust must ensure that patients who are referred to the trust have their referrals reviewed in a timely manner to assess the degree of urgency of the referral.
- The trust must ensure that the patients who require follow up appointments are placed on the waiting list.
- The trust should ensure there are adequate processes in place to ensure patients who self-present to the emergency department receive an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival.
- The trust should ensure that there is 16 hours of consultant presence available each day.
- The trust should ensure there are appropriate procedures in place for identifying seriously ill patients who self-present at the reception of the emergency department.
- The trust should ensure procedures are followed regarding the safe management of sharps boxes.
- The trust should ensure all staff have completed mandatory and role specific training.
- The trust should ensure the environment for children's provision in the emergency department meets the 2012 Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings.
- The trust should ensure staff are appropriately trained and supported to meet the requirements related to duty of candour.
- The trust should ensure an annual audit is carried out in line with the recommendations of The Royal College of Emergency Medicine (RCEM) guidelines; Management of Pain in Children (revised July 2013).
- The trust should ensure they take steps to address the accessible information standard in the reception area of the emergency department at Lincoln County Hospital.
- The trust should ensure mandatory training is completed in line with trust policy.
- The trust should ensure all staff are aware of the arrangements in place to respond to major incidents.
- The trust should ensure hourly rounding charts and charts used for monitoring fluid balance of patients are completed to ensure the health, safety and welfare of the service users.
- The trust should ensure medications are always handled safely, in line with legislation, the trust's policies and best practice guidelines.
- The trust should ensure venous thromboembolism treatment is prescribed in a timely manner and re-assessed after 24 hours.
- The trust should ensure there are measures in place to ensure patient medical notes are stored securely.

Action the hospital SHOULD take to improve

- The trust should ensure there are effective and consistent systems for learning from incidents to be shared across the emergency department.
- The trust should ensure the governance framework in the emergency department clearly identifies risks, responsibilities and actions required to ensure all staff raise patient safety incidents appropriately.
- The trust should ensure that the resuscitation trolleys and their equipment are checked, properly maintained and fit for purpose in the emergency department.
- The trust should ensure there are adequate processes in place to ensure handovers between the ambulance and the emergency department take place within 15 minutes with no patients waiting more than 30 minutes.

Outstanding practice and areas for improvement

- The trust should ensure continued engagement within the Oromaxillo facial service in order to further develop the service.
- The trust should consider 24 hour reception cover on the surgical emergency assessment unit
- The trust should consider a discharge co-ordinator post within ward areas.
- The trust should consider how the role of the domestic assistants support the ward team in relation to food serving and cleaning.
- The trust should ensure that grading of incidents is consistent and follows trust guidance.
- The trust should ensure that the new IT system supports accurate documentation of safety thermometer data.
- The trust should ensure that notes for patient's undergoing caesarean section are consistent including standardised documents.
- The trust should ensure that safeguarding supervision is provided regularly for all staff.
- The trust should ensure that accurate up to date maternal weights are performed on admission in order to prescribe weight dependant medication.
- The trust should ensure that the resuscitation trolleys on Bardney Ward are checked, and appropriate documentation completed.
- The trust should ensure that if recent NICE guidance is not followed then the current guidance includes an addendum to explain the current decision. (CG 190)
- The trust should ensure staff development programmes are supported and staff are encouraged to attend learning opportunities.
- The trust should audit the length of time patient's attending for emergency gynaecology appointments are expected to wait.
- The trust should ensure that within maternity service users feedback is captured.
- The trust should ensure that they audit the number of patients whose elective caesarean sections are delayed to the next day.
- The trust should ensure that action plans are made following audits, and a reaudit is performed, such as following the regular CTG audits.
- The trust should ensure outpatient and diagnostic services are delivered in line with national targets.
- The trust should ensure that incidents are correctly graded and there are effective systems in place to ensure learning from incidents takes place.
- The trust should ensure that there are sufficient documented procedures and records in place to provide assurance that ultrasound probes are decontaminated after use in line with the manufacturer's recommendations and in compliance with the Health and Social Care Act 2008, Code of Practice On the prevention and control of infections and related guidance.
- The trust should ensure that there is sufficient signage throughout the outpatient department to direct patients/visitors to the hand hygiene facilities that are provided to minimise the risk of spreading infection.
- The trust should ensure that the condition of health records enables the safe care and treatment of patients, compliance with information governance requirements and ensures patient confidentiality is maintained.
- The trust should ensure all staff working in the outpatient and diagnostic departments attend the trusts mandatory training programme as required by their role and professional responsibilities.
- The trust should consider reviewing the method by which MRI reports are transferred onto the Radiology Information System to ensure the risk of error during the transfer of data is minimised or removed.
- The trust should ensure that there are sufficient systems in place and utilised to minimise the risk of potential harm to patients. Sufficient time must be available to ensure comprehensive patient identity and procedure checks are completed prior to all diagnostic procedures being commenced.
- The trust should ensure that staff working in the radiology department have sufficient knowledge of the national diagnostic reference levels to be able to apply them appropriately when required.
- The trust should take action to ensure all staff working in the outpatient and diagnostic services receive an annual appraisal to ensure they are able to fulfil the requirements of their role.
- The trust should consider whether the action taken to reduce the back log of clinic letters waiting to be sent to GPs and patients following their appointment was effectively resolving the backlog of letters.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17(2)(b)</p> <p>Systems or processes must be established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• Staff in the emergency department were not appropriately trained and supported to provide the care and support needed by patients at risk of self-harm.• Clinical guidelines regarding the care and treatment of patients with mental health conditions were not available to support staff.
Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>Regulation 18(2)(a)</p> <p>Staff must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• Not all nursing staff in the emergency department had received appropriate supervision and appraisal.
Regulated activity	Regulation

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (2)(a)

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

How the regulation was not being met:

- Where patients had met the trust's criteria for sepsis screening, not all patients were screened in accordance with national guidance.
- The trust's sepsis protocol was not embedded with all staff groups to achieve and maintain high levels of compliance with sepsis identification and antibiotic administration.

Regulation 12(2)(c)

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

How the regulation was not being met:

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (2) (a)

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

How the regulation was not being met:

Requirement notices

- Ligature risk assessments had not been undertaken and ligature cutting equipment was not available in all required areas.
- There was an ineffective system in place to assess, monitor, and mitigate risks to deteriorating patients. Where patients had met the trust's criteria for sepsis screening, not all patients were screened or treated in accordance with national guidance.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

15(2) premises and equipment maintain standards of hygiene appropriate for the purpose they are being used.

How the regulation was not being met.

In OPD Clinic 6 (ENT) The clean utility room was not solely used for the purpose of storage/preparation of sterile/clean items. The staff kitchen also located in the same room.

How the regulation was not being met

In OPD clinic 6 (ENT) The scope decontamination room contained a stainless steel sluice type sink. that had occasional use to dipstick test/ dispose of urine.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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

How the regulation was not being met

Requirement notices

There was no procedure in place for checking the emergency buzzers in the outpatient departments. The emergency buzzers throughout the department were not routinely checked.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

(1) Systems or processes must be established and operated effectively to ensure compliance with the requirement in this Part.

(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

How the regulation was not being met:

As of the week of the inspection, there were 8,108 patient appointment outcomes, not completed and closed on the electronic record system.

We saw the availability, the condition and storage of medical records presented risks to ongoing care and treatment.

As of 11th October 2016, 1,805 new referrals had not been graded as to their degree of urgency for treatment or investigation. There were a further 9,000 patient records requiring validation.

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

HSCA 2008 (RA) Regulations 2014 Regulation 17 Good Governance. 17(2) (a) Systems and processes must be established and operated effectively to ensure the registered person assess, monitor and improve the quality of services provided in the carrying on of the regulated activity.

How the regulation was not being met

This section is primarily information for the provider

Requirement notices

Failing to meet incomplete referral to treatment national standard for three consecutive months. Failing to meet the majority of the cancer waiting targets Jan 2016 to September 2016.