United Lincolnshire Hospitals NHS Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

United Lincolnshire Hospitals NHS Trust (ULHT), situated in the county of Lincolnshire, is one of the biggest acute hospital trusts in England serving a population of over 736,700 people. The trust provides acute and specialist services to people in Lincolnshire and neighbouring counties. The trust has an annual income of £447 million and employs nearly 8,000 people.

In the last year the trust had around 642,000 outpatient attendances, around 145,000 inpatient episodes and around 147,000 attendances at their emergency departments.

The trust provides acute hospital care for the people of Lincolnshire from their sites in Lincoln, Boston and Grantham and also delivers services from community hospitals and centres in Louth, Gainsborough, Spalding and Skegness.

Between 5 October 2021 and 11 November 2021, we inspected four core services provided by the trust across two locations. We carried out an unannounced inspection of urgent and emergency care, Services for children and young people, Medical care (including older people's care) and a focused unannounced inspection of Maternity at Pilgrim Hospital and Lincoln County Hospital. We also inspected the well-led key question for the trust overall.

We carried out this unannounced inspection of services provided by this trust because the trust was placed in financial and quality special measures in 2017/18 and is currently placed into System Oversight Framework (SOF) segment 4 of NHS England & NHS Improvement (NHSEI) Recovery Support Programme (RSP). At our last inspection we rated the trust overall as requires improvement.

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Our findings

On 5, 6, 7, 8 October 2021 we inspected four core services provided by the trust across two locations. We inspected urgent and emergency care, Services for children and young people, Medical care (including older people's care) and Maternity at Pilgrim Hospital. At our last inspection, Urgent and Emergency Services and Services for children and young people were rated as inadequate overall. Medical care (including older people's care) and Maternity were rated as requires improvement overall.

At Lincoln County Hospital we inspected urgent and emergency care, Services for children and young people, Medical care (including older people's care) and Maternity. At our last inspection, Urgent and Emergency Services was rated as inadequate overall. Services for children and young people and Medical care (including older people's care) were rated as requires improvement overall. Although Maternity at the Lincoln County Hospital was rated good overall at our last inspection, we inspected this service because we had concerns.

We did not inspect Outpatients previously rated requires improvement because we are monitoring the progress of improvements to outpatients and had no concerns. We will re-inspect them as appropriate.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. Our findings are in the section headed ‘is this organisation well-led’. We inspected the well-led key question between 9 and 11 November 2021. A financial governance review was also carried out at the same time as the well-led inspection, this was undertaken by NHS England and Improvement (NHSEI). There was not a separate ‘Use of Resources’ assessment in advance of this inspection.

Our rating of the trust stayed the same. We rated them as requires improvement because:

- We rated safe and responsive as requires improvement and effective, caring and well-led as good.
- We rated six of the trust’s services as good and two as requires improvement. In rating the trust, we took into account the current ratings of services not inspected this time.
- We inspected maternity using our focused maternity framework and guidance. Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.
- In maternity services at Lincoln County Hospital we rated safe as requires improvement, the key questions of effective and well led remained the same. In maternity services at Pilgrim Hospital we reviewed actions the trust had taken to address areas for improvement identified in Maternity services following our 2019 inspection. We found the trust had taken sufficient action and improved Maternity services at Pilgrim Hospital and have therefore updated our ratings for this service. We rated the key questions of safe, effective and well led as good, the key questions of caring and responsive remained the same.
- Not all services had enough staff to care for patients and keep them safe and not all staff were up to date with mandatory training or additional safeguarding training.
- Medicines were not always stored safely and patient records were not always stored securely.
- Outcomes from national audits were not always positive and some services did not always use systems to manage performance effectively.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe or follow national guidance.

Our findings

- Services in urgent and emergency care were not designed in a way that always met the needs of local people, were inclusive and took account of patients' individual needs and preferences.
- People could not always access services when they needed to, and they did not always receive the right care promptly.
- Risks on the risk register, in some services, were not always effectively managed and not all risks were identified and escalated to reduce their impact.

However:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Most services controlled infection risk well. Staff assessed risks to patients, acted on them and mostly kept good care records. Most services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve services.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were mostly available seven days a week.
- Without exception, staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Services planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders had the skills and abilities to run services. They understood and managed the priorities and issues services faced. Improvements were observed in clinical leadership.
- Staff felt respected, supported and valued and were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Services engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

Outstanding practice

We found the following outstanding practice:

Trust wide

Our findings

- Significant improvements had been made to the safety and quality of care at the trust since our last inspection. The integrated improvement plan provided a framework for the trust to continue to deliver further improvements. Executive directors and NEDs consistently gave us the same message, that this was a proactive rather than reactive trust that was focused on doing the right thing for its patients and staff.
- The trust had been part of the 'Lincolnshire Stroke Transformation: 100 Day Challenge'. Stroke services had been identified as a system priority during 2019/20. Using both dedicated organisational development support and the 100 Day Rapid Improvement methodology significant work had taken place to implement a 'one team' approach to establishing an integrated, seamless pathway and a community based stroke rehabilitation service that was able to support stroke survivors, operating seven days a week.

Lincoln County Hospital

Medical care (including older people's care)

- The clinical engineering department had used innovation to support a patient to receive their care and treatment in a comfortable way.
- The trust took part in a 100 day challenge with the community service to allow a smoother and more rapid (where appropriate) transition from hospital to home/community for individuals who had suffered a stroke and to allow people to be managed and to manage confidently in the community. As a result of this the team awarded a Chief Allied Health Professional Office (CAHPO) Award in October 2021 for Innovation and Delivery of Systems in relation to the 100-day challenge and all the progress they had made this year. This was one of 7 awards given out in England.
- In 2019 United Lincolnshire Hospitals NHS Trust (ULHT) had become the first NHS trust in the country to be formally accredited by the 'Academy of FAB NHS Stuff'. The trust now had FAB Experience Champions identified on medical wards who acted as local leads for patient experience. Some of this work was new but aimed to engage with patients, families and their carers to improve care. For example, new monthly FAB Champions feedback on activities and patient panel discussions covered all aspects of care. This information all fed into the Medicine Division Patient Experience assurance report which provided an overview of themes and actions.

Pilgrim Hospital

Services for children and young people

- In the neonatal unit, staff had implemented an electronic 'ear' in the nursery. The device was programmed to signal a red light when noise levels increased above a certain level. It was thought that noise levels need to be moderated for neonates to keep them feeling safe and happy.
- Parents received training, guidance and support to carry out care such as tube feeding and utilised a set of parent competencies in a booklet to enable parents to carry out as much or as little as they felt comfortable with.
- The neonatal unit had two transitional rooms where parents stayed with their neonate for a few days to get accustomed to caring for their very tiny baby. The room was furnished with a double bed, wardrobe, kitchen, lounge area with TV, and bathroom facilities. There was room for siblings to visit. Parents still had access to nursing and medical staff on the neonatal unit whilst staying in the transitional rooms.
- Leaders had implemented a project with a community team where they worked closely with specialist community nurses to enable neonates who required ongoing specialist care such as continuous oxygen, could be discharged early with the support of a specialist community nurse.
- The service funded nursery nurses to complete their nurse training as part of a recruitment initiative.

Our findings

Medical care (including older people's care)

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Areas for improvement

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with two legal requirements. This action related to three services.

Lincoln County Hospital

Urgent and emergency care

- The trust must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.
- The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.

Maternity

- The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.

Pilgrim Hospital

Urgent and emergency Care

Our findings

- The service must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.
- The service must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Patients waiting on ambulances should be reviewed by medical staff within an hour and within 30 minutes where the national early warning score is five or more or requiring prioritisation. Regulation 12 Safe care and treatment.

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that staff complete mandatory training in line with trust targets. Including but not limited to the highest level of life support, safeguarding and mental capacity training.
- The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.
- The trust should ensure there are mechanisms for providing all staff at every level with the development they need through the appraisal process.
- The trust should ensure the requirements of duty of candour are met.
- The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.
- The trust should ensure they are using timely data to gain assurance at board.
- The trust should ensure all patient records and other person identifiable information is kept secured at all times.
- The trust should ensure it has access to communication aids and leaflets available in other languages.
- The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.

Lincoln County Hospital

Urgent and emergency care

- The trust should ensure that falls and mental health risk assessments and transfer documentation are in place for patients when they are required and that completion risk assessments and transfer documentation are audited.
- The trust should ensure, the paediatric area within the Emergency Department, nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health (RCPCH).
- The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.
- The trust should ensure effective systems are in place to review the service risk register.

Services for children and young people

- The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.

Our findings

- The trust should ensure an interpreter is used as per trust policy to ensure all young people, parents or guardians are able to consent to care and treatment and fully understand clinical conversations.
- The trust should ensure cleaning records are completed as per trust policy.
- The trust should consider discussing mixed sex accommodation with young people proactively rather than reactively.
- The trust should consider the use of a communication tool to support staff working with children who have additional needs.
- The trust should ensure that a patient's food and fluid intake is accurately recorded .
- The trust should consider adding specific action plans to the service risk register.

Medical care (including older people's care)

- The trust should ensure that safety checks of new ward environments are fully completed before moving patients.
- The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.

Maternity

- The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.
- The trust should continue to work towards increasing the number of midwives who are competent in theatre recovery to ensure women are recovered by appropriately skilled staff.
- The trust should improve the completion of safety, quality and performance audits to ensure these are consistently completed effectively, to enable safety and quality concerns to be identified and acted upon.

Pilgrim Hospital

Urgent and emergency care

- The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to.
- The trust should ensure patients at risk of self harm or suicide are cared for in a safe environment meeting standards recommended by the Psychiatric Liaison Accreditation network (PLAN) and mental health risk assessments and care plans are completed for all patients at risk.
- The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.
- The trust should ensure patients at risk of falling undergo a falls risk assessment and falls preventative actions are in place.
- The trust should ensure deteriorating patients are identified and escalated in line with trust policy.
- The trust should ensure the, paediatric area within the Emergency Department, nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health (RCPCH).
- The trust should ensure effective systems are in place to investigate incidents in a timely manner and identify and share learning from incidents to prevent further incidents from occurring.
- The trust should ensure clinical pathways and policies are updated in line with national guidance.

Our findings

- The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.
- The trust should ensure effective systems are in place to review the service risk register.

Services for children and young people

- The trust should consider all key services being available seven days a week.
- The trust should consider routine monitoring or auditing of waiting times for children to have a medical review as per the Royal College of Paediatrics and Child Health (RCPCH).

Medical care (including older people's care)

- The trust should consider giving ward managers direct access to training systems for their areas in order to monitor and action mandatory training needs of their teams on a more regular basis.

Is this organisation well-led?

Our rating of well-led improved. We rated it as good because:

- There was the leadership capacity and capability to deliver high quality, sustainable care.
- There was a clear vision and credible strategy to deliver high-quality sustainable care to people and robust plans to deliver.
- There was a culture of high-quality, sustainable care.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- There were clear and effective processes for managing risks, issues and performance.
- Appropriate and accurate information was effectively processed, challenged and acted on.
- People who use services, the public, staff and external partners were engaged and involved to support high-quality sustainable services.
- There were robust systems and processes for learning, continuous improvement and innovation.

However:

- The culture of the organisation did not always encourage openness and honesty at all levels within the organisation. Compliance with the duty of candour regulation had been variable however, the trust were taking appropriate action to address this.
- There were inconsistencies at some levels of leadership across the organisation in relation to governance awareness.
- Medicines management across the trust remained a significant challenge. However, the board were cognisant of these risks and were taking steps to address them.

Leadership

There was the leadership capacity and capability to deliver high quality, sustainable care.

Our findings

The trust board included five voting executive directors, one of whom was the trust chief executive, two non-voting executive directors and six non-executive directors (NEDs), one of whom was the trust chair. At the time of this inspection, the director of people and organisational development position was vacant and was being covered by the director of finance. There were effective systems in place to ensure that their portfolio was manageable. The vacancy was being recruited to. Two of the non-executives were in the process of retiring from the board and recruitment was in train.

The trust board was accountable for setting the strategic direction of the trust. The board was working effectively together to achieve its full potential. Leaders had the skills, knowledge and experience that they needed. We observed a strong, cohesive team with collective leadership at board level. All executive directors and NEDs were collectively and corporately accountable for the trust's performance. Our observation of trust board meetings and review of board papers evidenced that opportunities were regularly provided for the exchange of views between executives and NEDs, drawing on and pooling their experience and capabilities.

NEDs gave a clear and consistent account of their role within the unitary board. NEDs had a range of experience and backgrounds including leadership within the NHS; three, including the chair, had close knowledge of services in Lincolnshire through membership of the board of another trust in Lincolnshire.

The director of finance had joined the trust as deputy director of finance in 2018 and had been appointed as director in 2019. They were supported by an experienced deputy director of finance who was also an experienced and valued financial leader; and by an energetic and well-motivated finance team. The director's portfolio also included digital and HR; and from interviews it was apparent that there was a well-developed and empowered infrastructure in each department that mitigated the risk of such a broad leadership portfolio in a financially challenged trust.

The board recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation. There was a strong board development programme in place designed to improve the effectiveness and efficiency of the board.

Chair and NED development programmes were available to NEDs both internally and through NHS England and Improvement (NHSE/I). NEDs we spoke with told us they were aware of these and some had and/or were accessing programmes depending on their development needs.

The trust was committed to succession planning in order to identify and develop potential future leaders and senior managers, as well as individuals, to fill senior roles that could become vacant and avoid a department or service becoming vulnerable if the post was not filled quickly. Succession planning and talent management linked directly to the trust's Integrated Improvement Plan (IIP) under the "People" strategic objective. In August 2021 the trust successfully submitted a bid to become a pilot trust for the NHSE/I approach to talent management. This would align the trust to NHSE/I and would serve as a Lincolnshire systems approach. The pilot was expected to commence in Jan 2022.

Leadership and management development within the trust was supported through the Lincolnshire Talent Academy. The Talent Academy was formed in April 2015 within the trust, as an initial pilot to support the engagement of young people with the organisation and to influence future career choice. The Talent Academy supported staff at all levels, from entry level apprentices taking their first employed position upon leaving education, through to senior staff looking for further development.

Our findings

Executive directors and NEDs were visible and approachable. Ward and department visits by board members continued throughout the COVID-19 pandemic albeit, on a much smaller scale. In addition, some executive directors had been, on occasion, working clinically in ward and department areas. Reverse mentoring and 15-steps challenge were also used as tools for engagement with front line staff. The 15 steps challenge focuses on seeing care through a patient or carer's eyes and exploring their first impressions.

There was a leadership structure within the pharmacy team to support the delivery of care. A recent appointment of deputy chief pharmacists had improved this leadership capacity.

Appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We reviewed the personal files of four executive directors and two non-executive directors to determine the necessary fit and proper person checks had been undertaken. We found all files were fully compliant with FPPR.

Vision and Strategy

There was a clear vision and credible strategy to deliver high-quality sustainable care to people and robust plans to deliver.

There was a clear vision and a set of values, with quality and sustainability as the top priorities. The trust vision 'Outstanding Care personally Delivered 'was underpinned by five key values: Patient-centred; Safety; Excellence; Compassion and Respect. These values supported the trust's integrated improvement plan, a five year plan (2020-2025) that identified the key priorities for the trust.

It was clear during our core service inspection that significant improvements had been made to the safety and quality of care at the trust since our last inspection. The integrated improvement plan provided a framework for the trust to continue to deliver further improvements. Executive directors and NEDs consistently gave us the same message, that this was a proactive rather than reactive trust that was focused on doing the right thing for its patients and staff.

There was a robust, realistic strategy for achieving the trust's priorities and delivering good quality sustainable care. The trust was in year two of their strategy realised through the integrated improvement plan and supported through the trust's Outstanding Care Together Programme (OCTP). Four workstreams worked to deliver the trust's four strategic objectives: Patients, People, Services and Partners. Each strategic objective had an executive senior responsible officer (SRO), identified leads for each workstream and delivery lead for each project.

The strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. The trust was working with the whole Lincolnshire health and care system on proposals for improvements to services, improvements that aligned to the partners workstream.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who use services, and external partners.

Staff knew and understood what the vision, values and strategy were, and their role in achieving them. Staff at all levels 'walked' the trust values during the course of their work and were empowered to contribute to the strategic direction of

the trust. Throughout the core service and well led inspections we heard of many examples of service improvements made not only at board level but at ward and department level where staff were motivated and committed to improve the safety and quality of care patients received. This included for example, a reduction in falls and pressure ulcers and significant improvements within respiratory medicine.

The pharmacy operational plan 2019-21 detailed the activity of the pharmacy team and we were told the team were still working to this model. The trust single integrated improvement plan included the review of the pharmacy model and service within the improving clinical outcomes section.

Culture

There was a culture of high-quality, sustainable care.

Staff felt positive and proud to work in the organisation. There were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively. Throughout our core service and well led inspections, staff were enthusiastic, motivated and were keen to share with us their pride at working for this trust. From every conversation the inspection teams had with trust staff it was clear that the patient was at the heart of their work.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and we saw where appropriate learning and action had been taken as a result of concerns raised. Executive leaders told us they adopted an 'open door' policy and we heard of many examples from staff outside the executive team who felt comfortable raising their concerns with the executive team. However, a small number of staff told us they were fearful of raising concerns with their immediate line managers and that this was having a significant effect on their mental health.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. On 12 May 2021 the trust launched an electronic performance and appraisal management system for staff. This was implemented in response to the NHS people plan and the trust's integrated improvement plan, and to support staff in having meaningful conversations about their performance. The system was designed to facilitate quality, values based discussions and encouraged staff to have ownership for their own personal performance and development. The discussions also factored in wellbeing and behaviours.

Current appraisal compliance was 56.8% against a target of 90%. Compliance was 74.9% at the time of launch. The fall in compliance was attributed to staff not being accustomed to the new system, staffing and operational pressures. The board were sighted on appraisal compliance and were taking a number of actions to address this.

There was a strong emphasis on the safety and wellbeing of staff. The trust provided an all-round package of support for staff, helping them to look after their own health and to support those around them. On top of the core occupational health services, the trust had a number of innovative ways to support staff, including; in-house counselling, mental health first aid and mindfulness courses, training for staff and managers in emotional and wellbeing resilience, health check MoTs, an overall health and wellbeing assessment, physiotherapy, counselling training for managers and cognitive behavioural therapy training for managers.

Despite the extensive well-being offer from the trust, staff within pharmacy told us they did not feel valued by the organisation and that lip service was paid to support for their well-being. Examples were given of working long hours without breaks and staffing such that only one Band 3 post was allowed to take annual leave at a time. This had led to low morale.

Our findings

Equality and diversity was promoted within and beyond the organisation. A number of staff networks were in place to provide a safe space for discussion of issues and help to raise awareness of issues within the wider trust. Equality impact assessments (EIA) were shared across the wider Lincolnshire healthcare system and ensured policies, practices and decisions were fair, met the needs of staff and that they were not inadvertently discriminating against any protected group. The trust had a 'Our Inclusion Strategy' which set out the trust's strategic vision for all the work around the equality, diversity, inclusion and human rights agenda.

Without exception, staff told us they felt supported, respected and valued by the executive team and felt there had been a positive shift in the culture at the trust since our last inspection. However, a small number of staff felt there was work to do to develop those staff in middle management posts. Whistleblowing information received following the well led inspection suggested a small number of staff did not feel supported, respected and valued by their immediate line managers and that they had or were experiencing bullying and harassment. The 2020 National Staff Survey results placed the trust 58th out of 58 acute trusts nationally.

The executive team were committed to addressing behaviour and performance that was inconsistent with the vision and values, regardless of seniority. The organisation's approach to changing the culture was supported by credible plans and a palpable energy within the board. Throughout our interviews with executive directors and NEDs we heard the same message; trust staff and how they were feeling was integral to providing safe and quality care. The trust had signed up to the NHS England and Improvement (NHSE/I) Culture and Leadership Programme and within nursing and midwifery, a nursing and midwifery framework was in place to develop a culture that placed quality at the heart of everything staff did and was centred on the needs and experience of people who use services.

The Freedom To Speak Up (FTSU) index is a metric for NHS trusts, drawn from four questions in the NHS annual staff survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident. The FTSU index score for this trust was 73.6% and below the national average of 79%. Despite this, the trust had made improvements since our last inspection. The trust had appointed a FTSU Guardian, to work exclusively in this role, in September 2021. Staff had a much greater awareness of the role and staff were supported to raise concerns. The number of contacts since September 2021 had increased significantly with 41 contacts made compared to seven for the previous three months and 63 for the whole of 2020/21.

The culture of the organisation did not always encourage openness and honesty at all levels within the organisation, including with people who used services, in response to incidents. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.

For the reporting period October 2020 to September 2021, compliance with the duty of candour regulation had been variable (verbal compliance 84%, written compliance 68%). The board were sighted on duty of candour performance and had taken a number of actions to address this. Further planned actions included; commissioning a piece of investigative work to review the way in which the trust record duty of candour compliance to try and understand the variability in the data, refresher training for staff covering duty of candour requirements and a review of the trust's duty of candour policy and related documentation to ensure it was fit for purpose.

In addition to the planned actions, there was a process in place whereby the incident reporting system was reviewed daily by the clinical governance team. If an incident had been reported as meeting the duty of candour criteria, the team contacted the clinical team as a prompt.

Our findings

Governance

There were clear responsibilities, roles and systems of accountability to support good governance and management.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Progress against delivery of the strategy and local plans were monitored and reviewed. Monitoring of the integrated improvement plan was coordinated through the project lead where monthly support and challenge sessions took place with the relevant executive lead. Following the support and challenge sessions, an upward report was completed and fed into the finance, performance and estates committee on a monthly basis. In addition, the integrated improvement plan status report fed monthly into the people and organisational development and quality governance assurance committees. Board and committee papers we reviewed and interviews with executive directors and NEDs demonstrated there was bold decision making of the board that underpinned a well-planned and understood strategy. The consistent message we heard was the board were not afraid of change and felt it necessary to improve the safety and quality of services at the trust.

Since our last inspection the trust had reviewed its governance processes and structure and developed a business partner model approach to risk and governance, clinical audit and complaints. This allowed for triangulation of information to determine an accurate picture of performance across the trust. In addition to this, the trust had introduced an integrated clinical governance report for clinical divisions and a complaints, litigation, incident and Patient Advice and Liaison Service (PALS) (CLIP) report. Both provided a summary of key data at divisional and board level.

All levels of governance and management functioned effectively and interacted with each other appropriately. There were four board sub-committees; quality governance committee, people and organisational development committee, finance, estates and performance committee and audit and risk committee. The role of each board committee was to consider evidence provided by members of the executive team in relation to relevant corporate risks, to enable the committee to make an informed judgement as to the level of assurance that could be provided to the trust board.

There were medicines governance processes in place, and we could see that these had been strengthened following our last inspection. However, senior pharmacy staff told us they did not have clear lines of communication to escalate concerns and were unable to articulate concerns to people who were in a position to address them. We heard from senior trust leaders that there were escalation mechanisms in place and these were effective.

Executive directors and NEDs were clear about their roles and understood what they were accountable for, and to whom. However, there were inconsistencies at some levels of leadership across the organisation. Further work was underway with divisions to develop their understanding of what governance meant for them.

There was complaint sign posting and a complaint policy available on the trust's website for patients and services users to access. During our inspection of well led we reviewed six complaint responses. All responses were clear and transparent throughout and followed the Ombudsman's 'principles of good complaint handling' and 'principles for remedy'. At the time of this inspection the trust had a low number of outstanding complaints (29).

Management of risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Our findings

There were comprehensive assurance systems, and performance issues were escalated appropriately through clear structures and processes. These were regularly reviewed and improved.

The trust board was responsible for setting the strategic direction of the trust. This included defining the risk appetite, which was the tendency of the board to accept risk in particular situations and in pursuit of its goals. The trust's risk appetite was defined using the following scale:

- Open – prepared to tolerate a high level of risk
- Cautious – prepared to tolerate a moderate level of risk
- Minimal – prepared to tolerate only a low level of risk

A risk management strategy described the approach that the trust would take in managing risks to the achievement of its objectives through a formalised structure that included both corporate and operational risks. The trust had adopted an Enterprise Risk Management (ERM) approach, this approach enabled the trust board, its committees and senior management to consider the potential impact of all types of risk on its objectives and in doing so supported well-informed, risk-aware corporate and operational decision-making.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. The audit committee chair described how the committee and board gained assurance not only from auditors' reports but also from audit regulators. The programme of internal audit had been adapted during the period of the pandemic; but the head of internal audit had only been able to provide partial assurance on the operation of internal controls for 2020-21. They had greater confidence in levels of awareness and training on counter fraud and evidenced a reduction in the numbers of referrals.

We saw evidence of clinical audit relating to medicines reconciliation activity and audit activity presented to clinical groups relating to medicines errors. Both of these demonstrated poor levels of care and this was a recurrent problem. Trust senior teams were cognisant of these risks and were taking steps to address them.

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions and we saw there was alignment between the recorded risks and what board members said was 'on their worry list'. As part of this inspection we reviewed the trust's board assurance framework (BAF) and current corporate and service level risk registers. Through our review we were confident the trust board had sight of the most significant risks through the BAF and corporate risk register.

We were assured executive directors and NEDs had a robust oversight of all risks across the trust. During our interviews we were told a piece of work was currently underway to reconfigure the trust's risk registers and in turn strengthen the management and oversight of risk across the organisation. This work was supported by training and the implementation of an executive led risk register 'Confirm & Challenge' group. In September 2021, the trust introduced a risk register confirm and challenge meeting. This was chaired by the director of nursing who was the executive lead for risk and patient safety. At these meetings, over time, each division / directorate would have a deep dive of their risk register. This meeting would provide an additional level of challenge and oversight of risk issues and assurance that appropriate mitigations were in place.

Potential risks were taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The trust had a winter plan that brought together the culmination of key improvement schemes in planning for recovery and urgent care. The recent NHS Confederation (H2) guidance had been considered in order to produce the plan. The process for authorisation included internal and

external confirm and challenge and resulted in a trust and system plan that worked seamlessly together and one that would ensure safe services. The system coordination of the plan was to run through the Urgent and Emergency Care System Partnership Board. Internal monitoring of both planned and urgent care continued to run through divisional performance review meetings focussing on those elements aligned to the trust's integrated improvement plan.

The trust had been under particular scrutiny from regulators because of its financial and service quality challenges. The trust described itself as improving and starting to embed governance including financial governance; this assessment was confirmed by evidence provided from committee and board papers.

The trust had identified the ability to attract staff as being a very high risk with both service and financial impacts. It told us that it saw the development of a medical school at the University of Lincoln as a development key to improving recruitment and retention of staff.

The trust estate was recognised as requiring significant investment to make premises fit for purpose. The trust told us that the backlog maintenance requirement was c £250m on an asset base valued at £1.1bn. The trust told us about the processes that it had implemented to provide assurance about fire safety; and the improvements that it had made to the safety of infrastructure including electrical; ventilation and medical gas provision. The trust had used the findings of commissioned reporting engineers to build business cases for essential improvements and told us it was able to respond quickly to national ad hoc requests for capital bids.

Information management

Appropriate and accurate information was effectively processed, challenged and acted on.

Through the use of key performance indicators (KPIs) and divisional and trust wide integrated performance reports, the board had a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. Board papers we reviewed evidenced where information was used to measure for improvement, not just assurance.

Through interviews with board members and our review of board papers, including agendas we were assured quality and sustainability both received sufficient coverage in relevant meetings at all levels.

Information provided to the sub-committees and ultimately the board was of a good quality and enabled the NEDs to have an independent oversight and to provide constructive challenge to the executive directors.

There were clear and robust service performance measures, which were reported and monitored. The trust's integrated performance report (IPR) was presented to public board monthly and provided an overview of performance over time. However, from our review of board papers we were not assured the board was using timely data to gain assurance. For example, November's IPR referenced performance data from August/September 2021. Board members told us up to date data for example, emergency department waits, was discussed through the finance, performance and estates committee meeting.

Effective arrangements were in place to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. Triangulation of evidence to provide assurance was important to the board. Internal audits, matron walkabouts and safety huddles were amongst a number of measures the board used to validate information that was upwardly reported to the board. Where issues were identified, executive directors would hold divisions to account, in turn, NEDs would hold directors to account.

Our findings

Information technology systems used to monitor and improve the quality of care had yet to be realised. There was a significant reliance on paper to deliver clinical services which created challenges for clinical and other staff to perform their duties. With approximately 200 different clinical systems in use and no single information source containing all patient health information, clinicians needing to log into multiple systems separately.

The trust was one of 32 NHS organisations to receive support in the second wave of the Digital Aspirants programme. The money was to be used to develop the trust's digital strategy and business case to deliver an electronic health record. Plans and funding were also in place around introducing electronic medicines management systems across the trust. The business case for digital transformation was due to be approved in December 2021. Oversight of this was through the digital hospital group with upward reporting to the finance, estates and performance committee.

Arrangements were in place to ensure that data or notifications were submitted to external bodies as required. This included, but not limited to, the care quality commission, commissioners and the local authority.

There were robust arrangements (including appropriate internal and external validation) in place to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. The trust had four information governance data breaches which were reportable in line with the Information Commissioners Office (ICO) guidance in 2020/21. In all cases the ICO were satisfied with action taken by the trust and had closed the incident. No financial penalties were issued.

The Data Security and Protection Toolkit (DSPT), developed by NHS Digital (NHSD), sets out the standards and requirements in respect of receipts, storage and processing of information. The DSPT is structured into a series of numbered criteria. The DSPT is completed on a self -assessment basis each year. NHSD had extended the submission date for the 2020/21 DSPT from 31 March 2021 to 30 June 2021 whereby the trust had met all standards.

Engagement

People who use services, the public, staff and external partners were engaged and involved to support high-quality sustainable services.

People who use services, those close to them and their representatives were actively engaged and involved in decision-making to shape services and culture. The patient experience group (PEG) were committed to ensuring patients had the best possible experience in the trust. During our interview with the PEG team we heard and saw evidence to demonstrate a clear mantra being to understand what the process of receiving care felt like for the patient, their family and carers. The team gave many examples of where the public had been involved in shaping safe, quality services.

People in a range of equality groups were actively engaged and involved in decision-making to shape services and culture. A 'sensory loss group' had been set up as a sub-group of the PEG and included patients who were visually or hearing impaired in addition to, representation from charity organisations and Healthwatch. Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

People's views and experiences, including people in a range of equality groups had been gathered and acted on to shape and improve the services and culture. The team gave us many examples where changes had taken place as a result of patient stories at board, in the matron's forum and as part of quality improvement training. In addition, views and experiences had been sought from the travelling community and a number of community groups.

Our findings

The trust proactively engaged and involved staff (including those with protected equality characteristics) and ensured that the voices of all staff were heard and acted on to shape services and culture. The chief executive chaired the 'council of staff networks', an umbrella group in place to be the collective voice of four active equality staff networks; Women's Network and allies, Lesbian, Gay, Bi and Transgender (LGBT+) and allies, Black Asian and Minority Ethnic people (BAME) and allies and Mental And Physical Lived Experience (MAPLE) and allies. Furthermore, there was a collection of staff who were connected by the Armed Forces Network.

The trust's research and innovation (R&I) strategy (2021- 2024) and vision had been developed through targeted, informal consultation with internal and external stakeholders including:

- Patients and service users through the Lincolnshire Research Patient & Public Forum
- research management leaders from other local healthcare providers
- Local Authority / Local Universities
- trust staff
- R&I managers from other similar trusts
- The National Institute for Health Research (NIHR) Network East Midlands.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The trust was actively engaged with the development of the Integrated Care System (ICS) and described how it was developing closer links with system colleagues to develop financial strategies and plans to reduce the structural deficit that presently sat within the trust.

Relations between the four finance directors were described as highly collaborative and examples were given of task-and-finish groups to scope the service and financial impact of changes in prescribing; care closer to home; and musculo-skeletal care on the health system deficit. The levels of system ownership of the financial deficit were described as high with quantified financial and service benefits arising from the substitution of agency staff with a more clinically appropriate staff mix based in primary, community and social care organisations.

There was transparency and openness with all stakeholders about performance. The trust was an active participant in the Lincolnshire monthly system review meeting whereby there was attendance from multiple stakeholders including the care quality commission. At the November 2021 meeting the trust raised concerns around their cancer performance which showed the number of patients waiting longer than 62 days had increased and the 14-day standard was not being delivered, particularly in breast cancer where increased demand had outstripped extended capacity. This transparency and openness enabled a discussion amongst external colleagues whereby possible solutions were proposed.

Learning, continuous improvement and innovation

There were robust systems and processes for learning, continuous improvement and innovation.

Trust leaders and staff were committed to continuous learning, improvement and innovation which included participating in appropriate research projects and recognised accreditation schemes.

Our findings

The trust had an active improvement academy that supported innovation. Through working with NHS England and Improvement (NHSE/I) and external advisors, the trust had championed quality improvement at all levels of the organisation. By training staff in standardised quality improvement tools and methods, staff were empowered to continuously improve the quality of care and outcomes for patients.

Improvement pieces of work that had been completed by individuals who had completed the trust's quality improvement programmes included for example; improving compliance with heart failure management through accurate fluid balance monitoring and daily weights, introducing three dimensional imaging within the trust to ensure consistency with the National Institute for Health and Care Excellence (NICE) and national nuclear medicine guidelines, supporting staff to continue breastfeeding on return to work and creating a plus size equipment availability information sheet for physiotherapy staff.

The trust had been part of the 'Lincolnshire Stroke Transformation: 100 Day Challenge'. Stroke services had been identified as a system priority during 2019/20. Using both dedicated organisational development support and the 100 Day Rapid Improvement methodology significant work had taken place to implement a 'one team' approach to establishing an integrated, seamless pathway and a community based stroke rehabilitation service that was able to support stroke survivors, operating seven days a week. Improvements included for example, a reduction in length of stay (LoS) on the stroke unit in Lincoln County Hospital from 11 to seven days, launching a patient handbook that travelled with the patient from acute to community and beyond and initiating a dedicated stroke orthoptic clinic.

As a provider of NHS clinical research services, the trust were required to publish performance metrics relating to recruitment and delivery to clinical trials for the previous 12 months through the National Institute for Health Research. Areas of research included oncology, haematology, stroke, cardiology, paediatrics, dermatology, diabetes, midwifery, ophthalmology, respiratory, anaesthesia, general surgery gastroenterology and orthopaedics.

The trust research and innovation department was undertaking an ambitious three-year improvement journey. This was vital for the trust, its' staff, patients and service users as research and innovation was a thread through the core of trust business as described through the integrated improvement plan.

Research within the trust had delivered growth over 10 years, with active pockets across three of the sites (Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital). However, a change of leadership within the department and the subsequent unprecedented changes as a result of the Covid-19 pandemic provided a unique opportunity for the trust to review the department, consider their ambitions for research and innovation (R&I) and plan how they were going to get there. The purpose of the trust's research and innovation (R&I) strategy was to set out the vision and objectives of the trust in relation to R&I from 2021-2024, demonstrating how the trust would meaningfully embed R&I plans into the core business of the trust. It identified the key priorities for the R&I department over the next three years, ensuring that the trust focussed on the right things that would allow staff, patients and service users access to high quality research and innovation opportunities.

We saw evidence of members of the pharmacy team involved in discreet, externally funded roles that supported patient care. This included a project to facilitate safe discharge of people resident in care homes.

The trust was in the early stages of a '90 Minute Standard project' which was aligned to the integrated improvement plan and the surgery transformation programme plan for 2021/22. The aim of the project was to formalise the 90 minute standard process currently utilised in colorectal surgery and by applying a phased approach, roll-out the 90 minute standard to the other tumour sites within the other surgical specialities. Throughout the project, the main objective was to be to build a strong communication strategy to promote this best practice and the huge benefit it has on patient

experience at a time when cancer care is of key national importance. Strategically, this project was aligned to the "Patients" strategic objective and once completed, 100% of suitable patients that had been placed on the two week wait (2WW) list that did not have a suspicion of cancer would be informed within 90 minutes of that confirmation in those specialities.

As part of the transformation of emergency care at Lincoln County Hospital, patients needing urgent care were, from early summer 2021, now being treated in a new purpose built centre. The new state-of-the-art urgent treatment centre (UTC) provided a bright and welcoming entrance for the whole of the emergency department (ED), including a new reception and waiting area that followed the latest social distancing guidance, as well as 10 treatment rooms, a new X-ray and dedicated triage areas. The centre had been built next to the ED, allowing patients to be booked in at reception, assessed and treated in the right place for their needs. The final design had taken into account contributions by clinical and nursing staff from across the trust and partner organisations, as well as from patient experience and sensory impairment groups.

The completion of the UTC was the first phase in a programme of works that was to transform the hospital's ED. Other phases were to see the expansion of the existing ED to include: a bigger resus area with twice as many bays for the sickest emergency patients, a new paediatrics area with its own dedicated waiting room, treatment cubicles and a sensory area for the youngest patients and their families, additional treatment rooms for mental health patients, a new ambulance drop-off and bays created outside the front of the department with entrances directly into the resus and majors areas and additional clinical space, meaning that the emergency department would be able to accept patients from ambulance crews with improved speed and safety.

The trust had a Joint Advisory Group on Gastrointestinal Endoscopy (JAG) re-accreditation assessment visit in July 2021. At the time of our inspection, the draft report, for factual accuracy checking, was awaited. The JAG website showed this as being in the 'QA Process – for approval'. The verbal feedback provided at the time of the visit was positive.

Participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service was effective and learning shared effectively and used to make improvements.

As part of this inspection we looked at the trust's processes for reviewing deaths. The trust used the structured judgement review (SJR) methodology. We reviewed six cases where a SJR had been carried out. We saw the care received by patients who had died had been effectively reviewed, areas of learning had been identified and the reviews supported the development of quality improvement initiatives when problems in care were identified.

Respiratory medicine had been an area of concern identified by the trust in relation to the management of patients requiring non-invasive ventilation and other specialist respiratory treatments. The trust had undertaken significant improvement work to improve respiratory services. During late summer 2021 the trust opened a state-of-the-art respiratory unit at Lincoln County Hospital. The unit had been designed with 10 side rooms, all equipped with video technology and monitoring equipment. The unit was available to treat both inpatients and outpatients from across the county who had diseases of the lining of the lung.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Requires Improvement →← Feb 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
County Hospital Louth	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Lincoln County Hospital	Requires Improvement ➔➔ Feb 2022	Good ↑ Feb 2022	Good ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022
Pilgrim Hospital	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022
Grantham and District Hospital	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall trust	Requires Improvement ➔➔ Feb 2022	Good ↑ Feb 2022	Good ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022	Good ↑ Feb 2022	Requires Improvement ➔➔ Feb 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for County Hospital Louth

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Mar 2015	Not rated	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Rating for Lincoln County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022
Services for children and young people	Good ↑ Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022
Critical care	Good Oct 2019	Good Oct 2019	Good Oct 2019	Outstanding Oct 2019	Good Oct 2019	Good Oct 2019
End of life care	Requires improvement Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Urgent and emergency services	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022
Outpatients	Requires improvement Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Maternity	Requires Improvement ↓ Feb 2022	Good →← Feb 2022	Good Oct 2019	Good Oct 2019	Good →← Feb 2022	Good →← Feb 2022
Overall	Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022

Rating for Pilgrim Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022
Services for children and young people	Good ↑↑ Feb 2022	Good ↑ Feb 2022	Good → ← Feb 2022	Good ↑ Feb 2022	Good ↑↑ Feb 2022	Good ↑↑ Feb 2022
Critical care	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
End of life care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018
Urgent and emergency services	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Good ↑↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022
Outpatients	Requires improvement Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Maternity	Good → ← Feb 2022	Good ↑ Feb 2022	Good Oct 2019	Requires improvement Oct 2019	Good ↑ Feb 2022	Good ↑ Feb 2022
Overall	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement → ← Feb 2022	Requires Improvement → ← Feb 2022	Requires Improvement → ← Feb 2022

Rating for Grantham and District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Critical care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
End of life care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Outpatients and diagnostic imaging	Good Mar 2015	Not rated	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Urgent and emergency services	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Overall	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Pilgrim Hospital

Sibsey Road
Boston
PE21 9QS
Tel: 01522573982
www.ulh.nhs.uk

Description of this hospital

Pilgrim Hospital, Boston serves the communities of South and South East Lincolnshire. It provides all major specialties and a 24-hour major accident and emergency service.

Between 5 and 8 October 2021, we inspected four core services provided by the trust at this location. We carried out an unannounced inspection of urgent and emergency care, Services for children and young people, Medical care (including older people's care) and a focused unannounced inspection of Maternity.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate. we did not identify a breach of regulation in Maternity services at Pilgrim Hospital.

However, following our inspection of Maternity services we reviewed actions the trust had taken to address areas for improvement identified in Maternity services following our 2019 inspection. We found the trust had taken sufficient action and improved Maternity services at Pilgrim Hospital and have therefore updated our ratings for this service.

Following our 2019 inspection we issued a Section 29A Warning Notice to the trust as we found significant improvement was required to the governance in children and young people services at Pilgrim Hospital. Following a review of all the evidence from this inspection and a review of additional information provided by the trust before and following our inspection, we are satisfied that significant improvements have been made and the requirements of the Section 29A Warning Notice have been met.

Urgent and emergency services

Requires Improvement 

Is the service safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training, however not all staff had completed it.

Most registered nurses kept up to date with mandatory training. Following our inspection, the service provided us with a breakdown of registered nurse mandatory training compliance data. Registered nurses were compliant with the trust target in seven out of 11 modules. For those modules where compliance levels were not achieved, the service was close to achieving the target. Medical staff received but did not always keep up to date with mandatory training. Compliance levels had improved since our last comprehensive inspection in 2019. However, medical staff were not compliant with seven out of 11 modules. For example, major incident awareness (69%), information governance (79%), infection control and prevention (79%) and fire safety (86%). A plan for improving training compliance for both nursing and medical staff was in place.

Compliance to the highest level of life support training was not achieved for medical or nursing staff. Data provided to us following the inspection showed all 10 consultants and 78% of middle grade doctors working in urgent and emergency care had completed advanced life support adults (ALS) training. Furthermore, advanced trauma life support (ATLS) training had been completed by 80% of consultants and 56% of middle grade doctors. Training compliance data for basic life support (66%) was poor for registered nursing staff. However, 19 nurses had completed immediate life support training along with a further 20 nurses being trained in ALS. Data showed 80% of consultants, 72% of middle grade doctors and three out of five locum middle grades working at the trust had completed European advanced paediatric life support (EPALS) training. Training compliance data for paediatric basic life support (75%) was below expected standards for registered nursing staff. Only 38.6% or registered nurses had completed paediatric intermediate life support (PILS) and 65% EPALS.

Managers told us life support training compliance was impacted by the COVID-19 pandemic resulting in limited availability of external and internal training courses. However, a plan was in place to improve compliance. For example, it was expected 58% of nurses would have completed PILS and 71% completed EPALS by December 2021. Further training dates were booked for ALS and EPALS where staff had not completed it or due an update. We saw all medical staff who had not completed this training had a date booked. To mitigate risks, the rota was planned to ensure adequate numbers of medical and nursing staff were on duty with the relevant level of life support skills. On the day of the inspection, we saw nursing and medical staff working within the paediatric area within the Emergency Department had completed EPALS.

Staff received training on sepsis recognition and treatment. Training compliance levels had improved significantly. Data provided by the service following our inspection demonstrated 91% of staff in urgent and emergency care had completed sepsis training.

Urgent and emergency services

Mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules included key areas relevant to emergency department staff such as: health and safety, fire safety, patient moving and handling, infection prevention and control, equality and diversity, information governance and basic life support.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. On average 94% of registered nursing, medical and non-clinical staff had completed mental health training and 95% dementia training. Training in learning disability and autism was not provided, however, the service was in the process of developing an online training programme expected to be available to staff in December 2021.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept a log of staff training requirements which they used to remind staff when they were due to complete training. Compliance was reported to matrons through confirm and challenge meetings monthly.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it. Systems and processes to check nationally approved child protection information sharing systems were in place but not embedded or monitored by managers.

Nursing staff received training specific for their role on how to recognise and report abuse. The 90% compliance target was met for safeguarding adults and children level two and safeguarding adults' level three. However, was not met for safeguarding children level three (87%). A plan was in place to achieve compliance.

Medical staff were provided with training specific for their role on how to recognise and report abuse, however, compliance was poor. For example, data provided by the trust following our inspection showed 68% of medical staff had completed safeguarding adults and children level two, 67% had completed safeguarding adults level three and just over half (54%) had completed level three safeguarding children. However, medical staff understood how to identify a safeguarding concern and how to act on it.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff provided us with examples of where they have made safeguarding referrals for both children and adults. Details of local safeguarding arrangements were displayed in the department for staff to reference.

Staff generally followed safe procedures for children visiting the department. The paediatric area within the Emergency Department had significantly improved since our previous inspection. It was co-located within the adult emergency department with its own waiting area, separated from the adults waiting area. The department was accessible in and out by a keypad to ensure no unauthorised access. Staff told us children and young people at high risk of potential safeguarding concerns were reviewed by a senior paediatrician.

Systems were in place to review cases where children and young people left the department without being seen. Staff told us this did not occur often but demonstrated an understanding of how to deal with this. The trust safeguarding team were notified when a child or young person left, and a medical staff member attempted to make contact. General practitioners were notified through a discharge letter. The process was reviewed by the safeguarding team through quarterly audits.

Systems and processes to check nationally approved child protection information sharing systems were not embedded. Whilst there was a process in place to check an approved national child protection information sharing system for children attending the department, staff were not following this. This meant opportunities to review any current safeguarding risks associated with the child were potentially missed. Following the inspection, the service provided us with a plan for this to be reinstated fully by 30 November 2021. A flowchart describing the process had been shared within staff. The safeguarding team had commenced education sessions with key staff as part of team huddles and supervision sessions.

Systems were in place to add an alert to emergency department electronic patient records should there be a safeguarding concern. For example, to identify children and young people who attend frequently.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. Most areas we visited appeared clean. Chairs were wipe clean and most equipment appeared to be clean.

The service did not always perform well for cleanliness. Monthly audits demonstrated the service did not always meet the expected infection, prevention and control (IPC) standards. From July to August 2021 monthly IPC audit compliance averaged from 79% to 87%. An action plan was in place to improve compliance and was monitored monthly by the IPC group. Regular IPC briefings were communicated to staff to demonstrate expected standards. For example, in August 2021 a COVID-19 pandemic briefing was sent out following a rise in outbreaks with guidance for staff to protect themselves and patients.

Cleaning records were generally up to date to demonstrate areas were cleaned regularly. Cleaning records over the three-month period prior to our inspection showed all areas had been cleaned as per the cleaning schedule. However, the 'decontamination of bed space' following discharge record in cubicles was not completed to demonstrate the area had been appropriately de-contaminated. Staff could not confirm a room had been decontaminated before moving a new patient in.

Staff generally followed IPC principles including the use of personal protective equipment (PPE). We observed all staff were bare below the elbow and wore surgical face masks. Monthly matron IPC audits showed from April to September 2021 an average 90% compliance with hand hygiene practices and 98% compliance with adherence to PPE standards appropriate to the patients need.

Patients were routinely screened for signs and symptoms of COVID-19 when entering the department or during triage. A rapid assessment intervention treatment (RAIT) consultant was located in the reception area from 8am to midnight daily to stream patients into the most appropriate areas based on COVID-19 risk.

Staff wore surgical face masks, aprons and gloves when caring for patients with or suspected of COVID-19. Staff told us they only wore FFP3 masks and eye protection for aerosol generating procedures (AGP).

Green and blue pathways were implemented to separate patients with suspected or confirmed COVID-19. Perspex screens were erected to physically separate pathways to reduce the risk of cross contamination in the department.

Staff had access to appropriate hand hygiene facilities. Hand sanitising gel was readily available. We observed staff washing their hands with soap and water after patient care, including after removing gloves following contact with bodily fluids. Staff used alcohol gel following patient contact.

Staff cleaned equipment after patient contact. We observed equipment was generally clean including blood pressure monitors, electrocardiogram machines and trolleys. A health care assistant was allocated each shift to maintain a clean and tidy environment. Equipment was not always labelled to show when it was last cleaned. 'I am clean' stickers were not always used to indicate equipment had been cleaned to the correct standard. For example, we saw a commode and ultrasound machine did not have a sticker to let staff know if it had been cleaned since last use. However, we saw urinals did have 'I am clean' stickers. Monthly matron audits from April to September 2021 demonstrated on average 86% compliance with 'I am clean' stickers on commodes. In May 2021 this was 56% and June 2021 70%. Whilst stickers were not present, we observed equipment appeared to have been cleaned.

Single use equipment was used to avoid cross contamination between patients such as blood pressure cuffs.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Most patients had a call bell to hand and staff responded quickly when called. However, a patient who was high risk of falling did not have an accessible call bell. Once made aware staff ensured it was in reach of the patient. Call bells were answered quickly by staff during our inspection.

The design of the environment did not always follow national guidance. However, following our focused inspection in 2020 action was taken to improve the department. Reconfiguration works at Pilgrim hospital included a new x-ray room, an additional triage room, a modular waiting room, a fit to sit area and paediatric area within the Emergency Department. Patients were no longer cared for in the central area of majors. All majors' patients were streamed to a cubicle if they required a trolley. Furthermore, a fit to sit area had been created within majors and in the main waiting room. Patients attending by ambulance were held on ambulances when the department was at capacity. Whilst this was not what senior staff in the department wanted it allowed for patients to be monitored by ambulance staff whilst waiting for transfer into the department. In order to improve safety, patients were reviewed on arrival by the pre-hospital practitioner (PHP).

During our previous inspection we found the resuscitation area operated at full capacity for the duration of the inspection. In response the service created a fully equipped second resuscitation room with two bays as part of the 'green' pathway. This meant there were six resuscitation spaces available to accommodate surges in demand. The bay was intended to be stepped down to a majors bay when resuscitation capacity was not required. During our inspection, the department was under considerable pressure and the additional beds were used as majors.

Urgent and emergency services

The walk-in waiting room had undergone refurbishment and increased capacity to 16 chairs. Chairs were a mixture of sizes to accommodate people with different needs. They were wipe clean and were separated with perspex screens to ensure patients were separated to prevent the spread of COVID-19. Four chairs were dedicated to fit to sit streams and were monitored by staff.

The paediatric area within the Emergency Department had undergone significant refurbishment since our last inspection. The environment standards set out in the June 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings were being followed. The resuscitation bay was in the adult area, however, was at the end and decorated in child friendly colour and pictures. This was used by adults at times of peak demand, however, was prioritised for children and young people. In an emergency the nurse assigned to paediatrics would accompany the child with support from the paediatric emergency team.

Patients presenting with acute mental health concerns did not have access to a dedicated room which met national guidance relating to the provision of a safe environment. Staff told us a patient requiring additional supervision would be placed in an observable majors' bay. However, due to the layout of the department patients who were at risk of self-harm could have access to rooms and equipment which had the potential to cause harm. For example, the clean procedures room was easily accessible and we saw contained hazardous equipment. Toilets and bathrooms were accessible and contained ligature points. Following our inspection, the trust provided us with a plan to reinstate a mental health room (room 15) which was intended to be modified to meet appropriate standards. As an interim, the trust advised us any patient with mental health conditions requiring use of the room will receive one to one supervision. The trust confirmed they had also removed ligature risks identified in this room.

Storage space was limited across the department. For example, we saw unused trolleys stored in front of cubicle nine and ten blocking a walkway. Wheelchairs and linen trolleys were stored in corridors. Limited storage space meant a cubicle was used to store equipment. Areas containing equipment which could cause harm to a patient were not always secure to prevent unauthorised access. For example, we found the clean procedure room contained a cupboard with a 'slim body skin staple' and surgical scissors were on a trolley. The door to this room was always wide open throughout the inspection, we were therefore not assured staff took steps to ensure the environment was always secure. Following the inspection, the trust advised us locks would be fitted on cupboard doors in the clean procedures room to ensure there was no access to sharps.

Whilst the department was cluttered due to the demand exceeding the size of the area, staff made efforts to keep the patient cubicles as clutter free as possible.

Staff carried out daily safety checks of most specialist equipment. We reviewed safety checks on all resuscitation, airway and sepsis kits. All were checked as per the trust policy and included all relevant equipment. However, a difficult airway trolley in the blue resuscitation area had three items which had expired including two laryngeal mask airways and one tracheotomy tube. This was escalated to the nurse in charge who agreed to update the equipment and ensure checks were completed.

The service did not have suitable facilities to meet the needs of patients' families. The service had made considerable changes to the department since our previous inspection to ensure they could separate patients with COVID-19 and improve safety of patients in the department. This impacted the family room which was turned into a COVID-19 testing room at the time of the inspection. Staff told us when having sensitive conversations or delivering bad news, they would find a private space for families. Managers recognised this was not ideal but were restricted due to the limited space in the department.

The service had enough suitable equipment to help them to safely care for patients. Equipment was accessible and processes were in place to report when not working. Pressure relieving mattress toppers were readily available and were used for patients at risk of pressure tissue damage. Beds could be ordered for patients where a trolley was unsuitable, although there was limited room for beds in the department.

Staff generally disposed of clinical waste safely. Waste segregation was in place. Personal protective equipment (PPE) such as aprons and gloved were disposed of in clinical waste bins. However, we identified a blood bottle disposed of in a clinical waste bin rather than a sharps bin. This was escalated to the senior sister. Needle sharp bins in the department were not over full and the bins were dated and signed by a member of staff.

Assessing and responding to patient risk

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff did not complete all relevant risk assessments on patients admitted to the department and tried to remove or minimise risks.

Following our previous inspection, we found improvements had been made in meeting national guidance by the Royal College of Emergency Medicine (RCEM) relating to the initial assessment times of patients in the emergency department (ED). From April to September 2021 an average of 92% of adults and paediatrics were triaged within 15 minutes of arrival. During our inspection we reviewed 30 patient triage records and found 24 (80%) patients had been triaged within 15 minutes of arrival. Of the six that were not triaged within 15 minutes, the times ranged from 18 to 30 minutes.

However, during our inspection we found ambulance conveyed patients did not always undergo a face to face triage by the pre-hospital practitioner (PHP) at the point of arrival. The triage was taken from clinical information provided by ambulance staff who were mostly ambulance technicians as opposed to paramedics. This included an overview of the patient's complaints, condition and any clinical observations taken to enable the PHP to complete the triage tool. Ambulance crews continued to monitor patients and perform observations on the ambulance where patients could not be admitted to the department straight away.

Ambulance handover delays had got worse as the number of conveyances increased. The proportion of patients attending by emergency ambulance who waited between 30 and 60 minutes from arrival to handover at Pilgrim Hospital was consistently higher than the Midlands and England averages from 23 May 2021 to 12 September 2021. As of 12 September 2021, 29.6% of patients waited between 30 and 60 minutes, compared to 18% for the Midlands and 13.1% for the England average. Furthermore, over the same period the proportion of patients attending by emergency ambulance who waited over 60 minutes from arrival to handover had been getting worse. As of 12 September, the proportions were 30.9% for Pilgrim Hospital, 14.5% for the Midlands average and 9.6% for the England average.

From April to September 2021 there was an increase in the number of ambulance handovers delayed over 60 minutes from arrival. For example, in April 2021 the service reported 87 patients waiting longer than 60 minutes and by September 2021 it had risen to 446 patients. The service had experienced a significant increase in attendances. During our inspection, the emergency department was under high pressure and demand. Patients had long waits on ambulances. For example, on 5 October 2021 at 2pm we noted 49 patients were in the department with six ambulances waiting. The longest wait at the time we checked was 152 minutes. Furthermore, on 6 October, we noted a patient had been waiting on an ambulance for more than 4 hours. We were assured these patients were being appropriately monitored and escalated where required in line with trust policy.

Processes were in place for medical staff to complete face to face reviews of patients waiting over 60 minutes on an ambulance, however, this was not fully implemented. The trust standard operating procedure (SOP) for management of

reducing ambulance delays states patients who experience ambulance offload delays should be reviewed by a member of the ED medical team within one hour of arrival. During our inspection we did not observe this was routinely completed and ambulance staff commented this did not always take place. Following the inspection, the service sent us harm reviews of 17 patients who waited more than two hours on an ambulance. Only three of the reviews showed evidence the patients were reviewed on the ambulance by the emergency physician in charge (EPIC). In two cases, this was over an hour after arrival.

Furthermore, the SOP stated patients with a NEWS score of five or above or any clinical condition which required prioritisation should be reviewed by medical staff on the ambulance within 30 minutes. During our inspection we saw a consultant review a patient on the ambulance where the NEWS score had increased and another where pain levels had worsened. However, we were not assured this process was fully implemented. For example, harm reviews showed one patient arrived at 19.53 with a National Early Warning Score (NEWS) score of five which deteriorated to a score of eight at 21.43. There was no evidence the patient had been reviewed by the consultant according to the harm review. The patient was seen by a doctor at 22.45 once offloaded from the ambulance.

Whilst there were some concerns with patients not being physically reviewed by the PHP and medical staff whilst on ambulances, the service had improved its oversight and management of patients waiting on ambulances. Systems were in place to monitor patients. Patients were handed over in time order unless the clinical condition of the patient indicated otherwise. There was good communication between ambulance staff and PHP. We observed patients showing signs of deterioration being escalated and arrangements being made to re-prioritise for admission. For example, a patient who arrived and developed chest pain was immediately prioritised.

The PHP undertook hourly ambulance checks to review clinical observations taken by ambulance crew. This included reviewing signs of deterioration, pain assessments and comfort rounds. This was recorded in the patient casualty card.

The PHP liaised with the nurse in charge (NIC) and EPIC to update on patients waiting, clinical condition and overview of NEWS. Two hourly safety huddles took place between the NIC and EPIC to review all patients in the department with input from the PHP. Harm reviews were completed where patients waited longer than two hours and rapid reviews for those waiting over four hours. Of the 17 patients waiting more than two hours on an ambulance on the days of our inspection, none had come to harm.

Staff used a nationally recognised tool to identify deteriorating patients and generally escalated them appropriately. Patients were seen by a triage nurse for an initial assessment in time order, unless they presented with a red flag condition, such as suspected stroke or chest pain. A nationally recognised tool was used to triage patients which provided a risk rating of one to five. An emergency button was in the triage room used by the triage nurse if there was a clinical need for urgent prioritisation. If the patient required prioritisation but was stable a process was in place to escalate to doctors for immediate review. A consultant was located in the waiting room to ensure patients were streamed to the correct area and assisted the triage nurse in assessing patients. Clinically unwell patients were identified by a red/purple card system. We observed triage nurses escalating to the NIC and EPIC for medical review where there were concerns.

The department used NEWS2 to identify acutely ill patients, which supported staff with the early recognition of deteriorating patients. NEWS we looked at during our inspection were generally completed on time and escalated and monitored in line with frequency rules. We saw where required they were escalated to the NIC and EPIC. For children and young people, the paediatric early warning score (PEWS) was used in conjunction with the paediatric observation priority score (POPS). All paediatric patient records we reviewed had observations recorded and monitored.

Urgent and emergency services

During our inspection we randomly checked patients who were flagging as having a high NEWS score. We found in all cases action had been taken to escalate and review the patient. Following the inspection, the service provided us with outcomes of monthly high NEWS care audits. This demonstrated from May to September 2021 all patients attending with a high NEWS score by ambulance were triaged within 15 minutes and the average ambulance handover time was 5.5 minutes. The critical care outreach team had a presence within ED; to support staff in managing patients who had deteriorated.

Staff did not always complete risk assessments for each patient on arrival, using a recognised tool. Risk assessment tools such as skin integrity and pressure care body maps were generally included in the casualty assessment document completed by nursing staff. Additional documents were used including mental health and falls risk assessments.

We found variable compliance with completion of risk assessments. Fifteen out of 17 records we checked had an initial assessment of a patient's skin and where required a body map of any skin damage documented. Monthly matron audits generally reflected our findings during the inspection. From April 2021 to September 2021, an average of 82% of skin assessments checked had been completed within an hour of arrival and 100% patients had a pressure relieving mattress if required.

Falls risk assessments were not completed routinely within the emergency department. However, staff told us they would be completed for patients at risk of falling. We identified five patients at risk of falling. Three had been in the department more than four hours yet did not have a falls risk assessment completed. This was escalated at the time and they were subsequently completed. Matrons monthly audits from April to September 2021 demonstrated variable compliance with falls risk assessments. In May 2021 75% falls risk assessments were completed and in June 2021 83%. Compliance had improved to 100% from July to September 2021.

Mental health risk assessments were not routinely completed. However, staff told us they would be completed if a patient attended with a mental health related concern or following self-harm or attempted suicide. During our inspection we reviewed the care of a patient who attended following self-harm. Despite the notes indicating the patient was at 'medium' risk, there was no mental health risk assessment in place. This meant the service did not identify actions to be taken to reduce the risk of harm to the patient whilst in the department. This was escalated and the risk assessment was subsequently completed.

Staff knew about and dealt with some but not all specific risk issues. There were protocols in place to ensure patients requiring emergency interventions were placed on a pathway or received a package of care. Staff knew about conditions requiring prioritisation such as stroke and chest pain and we observed staff following escalation processes.

During our inspection we found improvement had been made in the identification and management of patients with sepsis or suspected sepsis. We reviewed seven patients who were identified at risk of sepsis. We found all had undergone a sepsis screen and the sepsis six bundle had been implemented and all actions completed within the hour including the administration of intravenous antibiotics. An audit completed from 4 to 17 August 2021 showed 90.6% of adults had a sepsis screen completed within 60 minutes and 93.4% of children and young people. Where required, treatment had commenced within 60 minutes in 90.6% of cases for adults and 100% for children.

Effective systems were in place to identify non-compliance with sepsis assessment and treatment protocols. The NIC and EPIC checked the electronic patient at a glance boards for patients with high NEWS to ensure they had been escalated and the sepsis bundle had been started. Where non-compliance was identified, rapid harm reviews were undertaken to identify whether the patient had come to harm or there were any care delivery issues. The trust section 31 urgent care report dated 20 August 2021, showed 14 harm reviews had been completed where staff had not completed a

sepsis screen and five where the full sepsis bundle had not been implemented within an hour. Furthermore, there had been three missed sepsis screens in the paediatric area within the Emergency Department. No harm to patients had occurred in any of these cases. We saw individual staffing issues were addressed and learning was shared during staff huddles. The service had a sepsis workbook and competency sign off process in place to improve practice.

Venous thromboembolism (VTE) risk assessments were completed in the medical assessment and doctors told us these were normally completed prior to prescribing preventative medicines to patients. VTE assessments had been completed in the records we checked, and patients had been prescribed preventative medicines where appropriate.

Where a patient was at risk of developing pressure tissue damage, we saw air flow mattress toppers were in place. Intentional rounding was in place and documented in the nurse led safety checklist. We found this was generally completed and included a repositioning record for patients at risk of developing a pressure ulcer. Monthly matron audits from April to September 2021 showed 100% of patients who needed one had a pressure relieving mattress in place.

Preventative actions to reduce the risk of a patient falling were not fully implemented or personalised. None of the patient records we reviewed documented personalised actions to be taken to reduce the risk of a patient falling. During our inspection we found preventative actions were not implemented in three out of five patients we observed who were at risk of falling. For example, none of the patients had a yellow wrist band, suitable footwear, bed rail assessment or lying and standing blood pressure. One patient had a one to one overnight, but this was not in place during the day. There was no reason documented why this had stopped. Staff told us their risk had reduced yet there was no evidence the risk had been reassessed. One out of the five patients did not have a call bell to hand and was not in a visible cubicle. Staff did however have an awareness of which patients were at risk of falling. Risks were discussed at shift handover and safety huddles. Matron monthly audits from April to September 2021 demonstrated poor (76%) compliance with lying and standing/sitting blood pressures. Patients at risk of falling were discussed at shift handover and safety huddles.

Patient trolleys were high and bedrails were in place which meant patients who were confused were at increased risk of harm from falling or harm through bed rail use. During the inspection we observed the trolleys were high and bed rails were in place for all patients and those at risk of falling. Most trolleys were at their lowest height but there was still a potential risk of harm, particularly with other preventative methods not being consistently implemented.

The service had 24-hour access to mental health liaison and specialist mental health support. Nurses made appropriate referrals to the mental health liaison team and psychiatrists when needed and sought support for patients who presented at the ED with behaviours which placed them or others at risk.

Staff did not always complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. During our inspection we reviewed one record where a patient was deemed to be medium risk of self-harm. However, there was no mental health risk assessment completed to ensure the patients' needs were being met and mitigations in place to reduce risk of self-harm. This was escalated and the risk assessment was implemented. Managers told us risk assessments were normally in place, however, did not audit compliance.

Staff shared key information to keep patients safe when handing over their care to others. We reviewed the handovers of six patient who transferred to another ward. The handover records were fully completed with key risk information to enable the incoming ward to implement measures to manage the patient safely.

Shift changes and handovers included all necessary key information to keep patients safe. We observed both the nurse handover and medical handover. We found the medical handover lacked structure in comparison to the nursing handover. All patents were discussed at medical handover but did not see evidence of overview of departmental risks,

staffing levels, plan to mitigate information technology failure. The nursing handover covered key areas including patients with high NEWS, at risk of pressure ulcers and falling, patients who lacked capacity. Nursing handovers provided an overview of capacity, staffing and escalation processes. We also saw managers or lead nurses go through current topics such as sepsis screening.

Nurse staffing

The service had some staffing vacancies. However, shifts were covered with bank and agency staff to ensure there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough nursing and support staff; however, action was taken to ensure patients were safe. Planned emergency department (ED) staffing was 12 registered nurses (RN) and eight healthcare assistants (HCA) day and night. This included the nurse in charge and pre-hospital practitioner (PHP). Managers told us the current staffing template did not meet the demand of the service. For example, the blue majors' stream was particularly challenged during our inspection. One RN and one HCA was allocated to cover the cubicles and walk-ins which staff told us was challenging for them due to the variety of the role as well as number of patients they were looking after. Furthermore, the triage nurse role was challenged at time of peak demand.

Skill mix was a challenge for managers due to the volume of new and junior RN's. For example, new nurses could not do triage training until they had been in post six months and some international nurses were still undertaking key competencies or were still supernumerary.

The service continued not to meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children nurses on each shift. The service had one registered nurse with level four paediatric competencies on duty 24 hours with support from a healthcare support worker. Improvements had been noted since our previous inspection. Paediatric skill mix was included on the main ED roster and the service ensured there were more than one staff member with paediatric competencies available so they could offer support if demand increased.

The number of nurses and healthcare assistants did not always match the planned numbers. On the day of our inspection the number of registered nurses met the planned level, but the service was down one healthcare assistant. The senior sister and band seven nurses were included in the numbers and working clinically to support the gaps in staffing levels to ensure all areas were covered. From June to September 2021, of the 2692 shifts unable to be filled by substantive registered nurses, 14.6% of these were unfilled. This meant 392 shifts were not covered by a nurse over this three-month period. Furthermore, over the same period 1776 shifts were unable to be filled by substantive healthcare support workers and 38% of these were unfilled. This meant 679 shifts were not covered by a healthcare assistant over this period.

The service took action to regularly assess and improve staffing levels. A staffing review was undertaken in September 2021 using a nationally recognised tool which recommended an adjustment to the staffing template. The recommendation, for an additional three registered nurses, had been submitted to the director of nursing for consideration. Managers told us it was expected the additional nurses would be allocated to the blue majors' stream, one to flex into the paediatric area within the Emergency Department and an additional staff member between 12-12 to support peak activity.

Urgent and emergency services

Staff told us staffing levels had improved. Processes were in place to escalate staffing concerns. The service worked with the other ED departments and where appropriate could swap staff to mitigate skill mix challenges. For example, moving staff with paediatric competencies. Healthcare support workers with extended roles had been introduced to support more challenging areas in the department such as triage.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Managers uploaded all required skills on the roster which was not approved until all skills were covered. Staffing gaps or increased pressures were added onto the ED risk tool which was updated twice per shift by the nurse in charge. Staff would be pulled from other areas in the trust if required as well as managers working clinically.

The roster was completed in advance and daily assurance calls took place with the nurse in charge to review staffing for the following day to confirm numbers and skill mix was correct.

The department manager could adjust staffing levels daily according to the needs of patients. Managers escalated department pressures through the matrons and the daily bed meeting. Additional staff could be requested to support the service to manage capacity and demand.

Staff were assigned to specific areas at the beginning of the shift depending on their experience and competencies.

The service had reducing vacancy rates. Data provided to us by the service following the inspection demonstrated a significant improvement with registered nurse vacancy rate. In April 2021 the vacancy rate was 25% which had steadily reduced to 4.3% in August 2021. The service had undergone a successful recruitment campaign, including an international nurse recruitment campaign. As of September 2021, there was a 1% vacancy rate for non-registered nursing staff.

The service had low and reducing turnover rates. Data provided by the trust demonstrated in April 2021 the turnover rate was 9.3% and had reduced to 4.5% by September 2021. The turnover rate for non-registered nursing staff was higher with an average 12.1% from April to September 2021.

The service had reducing sickness rates for registered nurses. From April to September 2021 the average vacancy rate was 6.4%. The rate was higher for non-registered nursing staff which averaged 10.1% over the same time period.

The service had high but reducing rates of bank and agency nurses. During our inspection we observed bank and agency nurses used to fill shifts. However, the rate of usage had reduced since new nurses had started. Managers limited their use of bank and agency staff and requested staff familiar with the service. Enhanced rates for bank staff started in November 2020 which increased uptake of shifts by substantive staff.

Managers made sure all bank and agency staff had a full induction and understood the service. Managers told us bank and agency staff were included in any topical training such as sepsis and pressure care to ensure practice was in line with trust standards.

Medical staffing

The service had some staffing vacancies. However, shifts were covered with bank and locum staff to ensure there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Urgent and emergency services

The service did not always have enough medical staff. The medical staff did not always match the planned number. There were gaps in the medical rota the service was unable to fill. For example, during September 2021 there were 28 unfilled medical shifts. On day one of our inspection there was a middle grade doctor unfilled shift and on day two a junior doctor unfilled shift. Medical staff told us they managed the service as safely as possible with the resources available. Medical leads said they reviewed staffing to ensure it was 'adequate', and as safe as possible.

The service had consistently high vacancy rates for medical staff. Data provided to us following the inspection demonstrated from April to September 2021 the average vacancy rate for medical staff was 22.2%. The consultant vacancy rate remained at 16.67% throughout this period and for middle grade Doctors was particularly high with an average rate of 34%. Junior doctors showed an increasing vacancy rate with 10.4% vacancy rate in August and September 2021.

The service did not have a paediatric emergency medicine (PEM) consultant as recommended in the Royal College of Paediatric and Children's Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings. However, there was a lead consultant for paediatrics and medical staff working in paediatrics had special interests. The model was supported by paediatricians working in the trust and systems were in place to ensure there was a paediatrician available in the event of deterioration. The senor leadership team recognised this was an area for improvement.

The service took action to regularly assess and mitigate and medical staffing risks. The service reviewed its skill mix of medical staff on each shift. Staffing levels were discussed at handovers and medical staff were assigned areas to work based on skill mix. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service had high rates of bank and locum staff. The service was committed to ensure locum cover was available when required. The locums used were regular doctors who had worked in the service for some time. Managers could access locums when they needed additional medical staff. The service utilised bank and agency medical staff to ensure the service had adequate cover due to the high vacancy rate. However, it was expected the reliance on agency would reduce once all posts recruited into had commenced employment.

Significant improvements in medical staffing and recruitment had been made. The service agreed an uplift in medical staffing resulting in increased numbers of consultants and middle grade doctors being recruited. There was reliance on agency and locum staff. For example, on the first day of our inspection there were five locums covering middle grade and junior doctor shifts. Recruitment of middle grade doctors had been a challenge; however, most positions had been recruited to at the time of the inspection and awaiting start dates. Where there were shortages and demand was high consultants acted down into more junior positions. The service always had a consultant on call during evenings and weekends.

At our last focused inspection, we reported there were eight whole time equivalent consultants on duty with only one being substantive. Significant improvements were seen during our inspection. All consultants on the rota the week of the inspection were substantive. The service was able to meet recommendations from the Royal College of Emergency Medicine (RCEM), that consultant staffing in the ED to be present in the ED for a minimum of 16 hours a day. Consultants cover was provided Monday to Friday 8am to midnight. On call cover was provided at all other times. At times of peak demand, consultants would work extended hours. The service had recruited to all 12 consultant posts with two awaiting a start date.

The service had made significant progress with recruitment, however, start dates for successful candidates had been impacted by the COVID-19 pandemic. It was expected all prospective candidates would be in post early 2022.

The service had consistently low turnover rates for medical staff. The turnover rate for both consultants and middle grade doctors from April to September 2021 was 0%.

Sickness rates for medical staff were low. The average sickness rate from April to September 2021 for all grades was 1.35%.

Managers made sure locums had a full induction to the service before they started work. Locums working in the service had an induction including an orientation and were included in departmental meetings and safety huddles. New doctors were given the opportunity to shadow before starting and we saw this was included on the medical rota.

Records

Records were not always stored securely. Staff did not always keep detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Patient notes were easily accessible but not always comprehensive. Nursing and medical staff had access to patients' paper and electronic records. Most sections of the casualty assessment were completed; however, the content was minimal and lacked detail of patients individualised needs. Risk assessments were not always completed for patients with specific needs. For example, we found falls and mental health risk assessments were not consistently used for patients who required them. Records were regularly updated to record two hourly care rounding, however, the content varied with lack of standardised approach to information recorded.

When patients transferred to a new team, there were no delays in staff accessing their records. Paper records were transferred with patients to other departments within the hospital and electronic records were available throughout the trust. Patients who were not admitted, had their notes scanned in by administrative staff.

Records were not stored securely. Throughout our inspection we observed patient records being left out and unattended on trolleys in walkways. For example, we saw patient record on a trolley in a corridor outside of room 15. We raised this with managers who removed the records, however we continued to see records being placed there throughout out inspection.

Medicines

Staff did not always follow systems and processes when storing medicines, however, did when prescribing, administering, and recording medicines. Medicines were not always locked away.

Staff did not always follow systems and processes when storing medicines. During our inspection we found the medicine cupboard in the green resuscitation room which was being used as a majors cubicle unlocked and containing intravenous (IV) antibiotics. The cupboard had a keypad lock; however, it did not work therefore could be accessed by unauthorised persons. We also found a store cupboard in the same room contained several IV paracetamol infusions. This was not intended for a medicines cabinet and was not lockable. The door to the room was always open and used by patients. Staff told us the lock had not worked for some time, yet ward storage audits undertaken from April to September 2021 indicated 100% drug cupboards were always locked which suggested the cupboard had not been effectively checked. Once escalated to the senior sister these were moved immediately and the lock quickly fixed.

Not all liquid medication bottles had open dates recorded that were stored in the medicines room. For example, we found oral morphine, peptic and nurofen for children had been opened with no date recorded to indicate when it was opened.

Urgent and emergency services

We reviewed fridge temperature checks from August to September 2021 and found there were four occasions the temperature went out of range. On two occasions there was no evidence of any action taken to escalate this to pharmacy, therefore we were not assured the correct steps for escalation were followed to ensure the medicines were safe to be used. This is something we identified at our previous inspection and were not assured it had improved.

The service routinely monitored medicine room temperatures.

Staff followed systems and processes when safely prescribing, administering and recording medicines. Medicines administration records were maintained to show medicines that had been prescribed had administered. We reviewed five medicine charts and found allergies were recorded in all records. Medicines were administered on times indicated and antibiotics were administered in a timely fashion when indicated.

Controlled drugs were stored and recorded following policy. Twice daily checks were undertaken, and any discrepancies were reported and investigated. We saw pharmacy team audits of controlled drug logs were regularly recorded.

Venous thromboembolism (VTE) protocols were in place and completed for patients along with appropriate prophylactic medicine

We saw information about medicines administered went with the patient to ward when they were admitted from ED.

Staff reviewed patients' medicines regularly. Medical staff recorded medicines already prescribed and when last taken on the casualty card. Any medicines administered by ambulance crew were also recorded and time administered.

Staff followed current national practice to check patients had the correct medicines. We observed staff checking patients details before administering medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts and medicine incidents were discussed in daily huddles.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The service had a chemical restraint policy and procedure in place. Decision making procedures were in place to aid staff to use least restrictive measures first. A rapid tranquilisation and chemical restraint checklist was in place. Medical staff we spoke to understood the procedures. Matron audits from April 2021 to August 2021 demonstrated 100% compliance with policy where patients were administered chemical sedation.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses however, this was not always done in a timely manner. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, learning was not always fully implemented. When things went wrong, staff apologised and gave patients honest information and suitable support but not always in a timely manner. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff could provide examples of incidents they had reported and whether improvements had been made as a result.

Urgent and emergency services

Staff raised concerns and reported incidents and near misses, but this was not always done within timescales outlined in trust policy. For example, we reviewed three serious incident reports and noted a delay in reporting. One was not reported for 31days following the incident, another for 18 days and another for six days. Staff told us they escalated incidents to the nurse or consultant in charge at the time.

Serious incidents were reported. From September 2020 to August 2021, ten Serious Incidents (SI's) relating to urgent and emergency care were reported at Pilgrim Hospital.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. However, three serious incidents we reviewed showed duty of candour was not applied in line with trust policy. For example:

- Incident one – occurred on 4 June 2021, reported on 23 June 2021 and duty of candour applied verbally and in writing on 17 August 2021.
- Incident two – occurred on 30 March 2021, reported on 30 April 2021 and duty of candour applied 7 July 2021.
- Incident three – occurred 9 April 2021, reported 15 April 2021. Whilst duty of candour was applied on the day of reporting, this was verbal, and no written duty of candour applied.

Incidents were not always investigated in a timely manner and there was a backlog of incidents requiring investigation. However, significant improvements had been made investigating the back log since our previous inspection in 2019 where there was a back log of over 1000 incidents. Managers told us this had reduced to approximately 140 at the time of the inspection and a plan was in place to continue to address the back log.

Managers investigated incidents thoroughly. We reviewed SI reports and saw a thorough investigation took place with key learning identified to improve. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff notice boards contained information and earning relating to serious incidents which had occurred within the department and elsewhere. Staff told us they received feedback from incidents they reported. Staff could describe learning from historical and recent incidents which occurred at the service and other areas within the trust. For example, we observed learning was shared across sites following an incident resulting in a missed diagnosis of aortic dissection. Managers debriefed and supported staff after any serious incident.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at monthly governance meetings and shared with staff at medical and nursing handovers. A newsletter was produced monthly where learning from incidents including serious incidents were shared with staff. Managers and staff told us they used social media platforms to communicate learning with staff to ensure learning was widely disseminated and consistently shared. Mortality and morbidity meetings took place bi-monthly where reviews of patient's care and treatment were undertaken, reviewed and learning shared. Feedback following medical examiner reviews was shared with staff at local governance meetings.

Evidence that changes had been made as a result of feedback was variable. For example, managers told us they had introduced a ward handover document for staff to complete and document key information when handing patients over to wards. We reviewed six records of patients who had been transferred and these were completed. However, we were not assured learning from falls related incidents had been fully implemented as we observed three patients who were high risk of falling without a falls risk assessment and falls prevention practices in place.

Urgent and emergency services

The service had no never events on any wards. Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Requires Improvement 

Evidence-based care and treatment

Clinical pathways and policies were not always updated in line with national guidance. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Staff followed the most up to date policies to plan and deliver high quality care according to best practice and national guidance. However, policies were not always up to date. For example, the guideline for the assessment of acute chest pain was last reviewed in 2018 and was due to be reviewed in August 2021. We also identified the mental health risk assessment had not been updated to reflect changes with the footprint of the department and removal of the mental health room. This had a significant impact on the safe management of patients at risk of self harm. Whilst staff appeared to be aware of pathways, they could not always sign post us to where to find local guidelines.

The standard operating procedure and flowchart for identification of patients presenting with potential sepsis for adults had been revised following our previous inspection.

The service had a programme of monthly quality audits to assess compliance against best practice. For example, sepsis, pain management and diabetes care. Matrons completed monthly quality audits which included reviewing records, speaking to patients and observations. This was put into a report and triangulated with daily department assurance reports to discuss with local managers to set actions to improve through monthly confirm and challenge meetings. Two hourly nurses in charge checks were completed to assess compliance with documentation throughout the shift. Issues were addressed at the time with staff and where required, support from practice facilitators was put in place to support learning.

Processes were in place to protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. However, we did not see evidence these processes were fully implemented. Documentation was in place which directed staff on managing patients presenting with a mental health condition. We reviewed one set of notes for a patient presenting with mental health concerns and self-harm. However, there was no mental health risk assessment in place to determine the patients background, individual needs, risks and actions to prevent the patient coming to harm. Audits were not completed to assess staff compliance with mental health risks assessments to provide assurance they were consistently implemented.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff were aware of patients who required extra support with their mental health and wellbeing. Notes were appropriately flagged, and specific needs were discussed at handovers.

Nutrition and hydration

Staff did not assess all patients using a nationally recognised screening tool. Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff did not use a nationally recognised screening tool to monitor patients at risk of malnutrition. Screening for malnutrition was completed on admission to a ward. However, many patients were in the department a long time and could arrive with a poor nutritional status.

Staff generally made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Two hourly comfort rounds were in place where food and drinks were offered. The service had recently introduced hot food for patients with extended stays in the department. Support was provided to patients who needed assistance with food and fluid intake. Matron audits from April to September 2021 demonstrated all patients received nutrition and hydration in line with their individual needs. The service did not have any staff trained to complete swallow assessment for patient with dysphagia, but managers told us arrangements would be made for patients to be assessed on the acute medical short stay ward (AMSS). There were 17 patients referred and seen in AMSS in Pilgrim in the three months prior to our inspection.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff recorded on the comfort round log in the casualty documentation where patients had been offered and accepted food. Where required fluid balance charts were in place and generally up to date. Matrons monthly audits demonstrated improvements with fluid balance monitoring across nine measures which in August and September 2021 was 100% compliant.

Specialist support from staff such as dietitians was available for patients who needed it, however there was not speech and language therapy service provided in accident and emergency.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and generally gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Improvements had been made since our comprehensive inspection in 2019. Pain scores were documented at the point of triage in 16 out of 19 records we reviewed. This included two paediatric patients. One of the patients where a pain score was not documented was given timely analgesia. All patients we spoke to told us they had been asked about their level of pain and offered analgesia if in pain. Matron quality audits from April 2021 to September 2021 demonstrated 100% compliance with pain assessment measures.

Staff told us they used specific pain assessment tools for patients with dementia or a learning disability. Service leads felt this was an area for improvement. Work was being undertaken to implement a visual scale to use for patients with communication difficulties which would feature in regular pain audits.

Patients generally received pain relief soon after it was identified they needed it, or they requested it. Patients told us they received pain relief quickly after they were assessed in most cases. We found analgesia was generally administered in a timely manner. However, in two records we found a delay of more than two hours. In one case this was a result of staff having difficulty cannulating and the other impacted by ambulance delays. Monthly matron audits demonstrated improvements in action being taken and documented in response to pain. From April to August 2021 the average compliance was 80%, however in July and August the expected standards were met.

Staff prescribed, administered and recorded pain relief accurately. For patients brought in by ambulance where medicines were prescribed, staff recorded this on this on the casualty card along with medicines prescribed at point of triage. We did not see any prescribing or recording errors on prescriptions.

Urgent and emergency services

Patient outcomes

Staff monitored the effectiveness and quality of care and treatment. Outcomes from national audits were not always positive.

The service participated in several national clinical audits. This included the Royal College of Emergency Medicine (RCEM) audits:

- RCEM Audit: Vital signs in adults 2018/2019
- RCEM Audit: Feverish child 2018/2019
- RCEM Audit: VTE in lower limb immobilisation 2018/2019
- RCEM Audit: Assessing Cognitive Impairment in Older Adults 2019/2020.
- RCEM Audit: Mental Health (Self Harm) 2019/2020.
- RCEM Audit: Care of Children in the Emergency Department 2019/2020.

Some of the data submitted to national audits was incomplete.

Outcomes for patients were not always positive and did not always meet expectations or national standards. The service participated in the Trauma Audit and Research Network (TARN) audit. Data was collected from April 2016 to March 2018. Outcomes were not always positive as follows:

- 0% of eligible patients received tranexamic acid within three hours of injury. This was lower than the TARN aggregate.
- Crude proportion of patients with severe open lower limb fracture receiving appropriately timed surgery was 10% which was much lower than the TARN aggregate (32%) against a target of 100%.

More recent data published for three TARN audit measures found:

- For the reporting period 1 January 2020 to 31 December 2020, all eligible patients received tranexamic acid within three hours of injury.
- The crude median time from arrival to CT scan of the head for patients with traumatic brain injury from January 2018 – May 2021 was one hour 28 minutes. This takes much longer than the TARN aggregate which is 33 minutes and against an audit standard of 60 minutes.
- The risk-adjusted in-hospital survival rate following injury out of every 100 patients, from January to May 2021 was as expected with 3.2 additional survivors.

Managers and staff did not use results from national clinical audits to improve patients' outcomes. Not all managers knew what national audits the service participated in. We did not see evidence there was regular review of national audit outcomes or actions to improve.

Managers and staff carried out a programme of local audits to check improvement over time. Regular local quality audits were undertaken, and the results were fed back into the trust's internal quality assurance systems. Managers used information from the audits to improve care and treatment. Improvement was checked and monitored. Systems were in place to check and monitor performance against standards daily through nurse in charge audits and monthly assurance audits.

Managers shared and made sure staff understood information from quality audits but not national patient outcome audits. Audit results were shared with managers who provided feedback to staff in newsletters and daily huddles. However, we did not see evidence outcomes from national audits was shared with staff.

The service had a lower than expected risk of re-attendance than the England average. The reattendance (within seven days of previous attendance rate) was mostly lower than the Midland average and consistently lower than the England average from August 2019 to July 2021.
In July 2021 the reattendance rate was 7% compared to the Midland average of 9.7% and England average of 8.9%. This increased to 8.3% in August 2021 against a national average of 8.6%.

Competent staff

The service had a plan in place to make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Not all staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers kept an up to date record of staff competencies they had received training and sign off in. A plan was in place to train and assess staff skills in all areas. The department was run by senior nurses who were experienced in providing emergency care. However, due to a need to increase nurse staff numbers, many nurses were junior, new to the service or were international nurses who had recently joined the services training programme. This group of staff did not have all the necessary skills to meet all patient needs, although there was a comprehensive training programme to address this. For example, 63% of registered nursing staff had completed Manchester triage training. The service was unable to book junior nurses on until they had undergone six months in post. There was a plan for this to be completed and two staff were booked on to training in December 2021.

All eligible registered nurses with skills to work in the paediatric area within the Emergency Department had completed level four paediatric competencies. All staff had to undergo a two-day training before being signed off as competent to work with children and young people. Managers told us staff had been trained and assessed as competent to triage and assess children and young people using POPS (Paediatric Observation Priority Score) and PEWS (Paediatric Early Warning Score) and undertake an initial assessment within 15 minutes of arrival to ED.

Junior doctors were provided with opportunities for skill development. For example, ultrasound training sessions were provided.

Managers gave all new staff a full induction tailored to their role before they started work. The induction period was flexible to accommodate individual learning requirements and new nurses told us they were happy with the training and support they were receiving. All substantive staff completed new pressure care e-learning. New starters received additional training on ED standards.

All new doctors attended an induction and were provided with opportunities to shadow.

The clinical educators supported the learning and development needs of staff and managers made sure staff received any specialist training for their role. A clinical educator worked in the department to support junior staff to develop competencies and facilitate any localised training for experienced staff.

Sepsis practitioners offered coaching and one to one support for staff in identification and management of sepsis. They supported the sign off of staff competencies and attended huddles to support staff knowledge.

Junior staff spoke highly of the support they had received from practice facilitators in supporting them to develop skills and undergo competency sign off.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, not all staff had an appraisal within the 12 months prior to our inspection. For example, 97% medical staff had received an appraisal, however, only 46.7% of registered and non-registered nursing staff had received an appraisal.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, newly appointed band seven nurses had been booked on to leadership training to support them in the management aspect of their role.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors had access to regular training which covered their learning needs. Weekly junior and middle grade doctors training sessions took place. Feedback from junior doctors about their experience and access to clinical supervision in the department was positive.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings could be attended in person or using video conference facilities. Team meeting minutes and outcomes or actions were shared with staff via email, social media or through a monthly newsletter. Additionally, relevant messages and updates from team meetings were shared at the daily huddles and board rounds.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, band two healthcare assistants were given opportunities to provide extended skills such as completing electrocardiograms.

Managers identified poor staff performance promptly and supported staff to improve. Poor staff performance was identified promptly. A new nurse leadership structure had been implemented in the ED which allocated a group of junior staff to a dedicated band seven nurse. This allowed close supervision of junior nurses and improved the early identification of any extra training which may be required on an individual basis.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Four times daily huddles took place between medical and nursing staff to review each patient. Staff told us relationships between staff in the department had significantly improved and disciplines respected each other's roles. We observed medical and nursing staff working well together with appropriate challenge when necessary.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, frailty pathways were in place. A frailty team visited the department daily Monday to Friday to assess and support safe discharge of patients. This was a nurse led model at Pilgrim site who were supported by consultants on other sites.

Staff could call upon the children and young people services for advice and support and to review patients where required.

Urgent and emergency services

The service had developed good working relationships with the local ambulance service. We saw effective communication take place during our inspection.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Mental health liaison nurses attended the department to review patients.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. There was suitable support from diagnostic services elsewhere in the hospital such as pathology, and radiology including Computerised Tomography (CT) to support the provision of care in the emergency department. Some imaging was available in the department including plain film x-ray and ultrasound. COVID-19 testing was undertaken in the department to improve the diagnosis and segregation of patients.

Health Promotion

Staff gave patients limited practical support and advice to lead healthier lives.

The service did not have relevant information promoting healthy lifestyles and support. The waiting room did not contain information leaflets for patients.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Assessment of a patient's physical, psychological and social needs formed part of the admissions booklet. Patients were referred to their general practitioner for continuing support if required. Staff knew how to refer to local drug and alcohol support services.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff did not keep up to date with Mental Capacity Act training. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Not all staff kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance data provided to us following the inspection showed less than half of medical staff had completed this training (45%). For medical staff this was worse than at our previous comprehensive inspection in 2019. Compliance was below the trust target for non-registered clinical staff (81%) and above the target for registered nursing staff (94%). However, most staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Most consent was gained verbally although we saw formal written consent was obtained when required, for example to undergo some diagnostic tests. Some staff had clearly recorded they had sought consent from a patient before carrying out an intervention. Patients provided examples where staff had sought consent. For example, when undertaking observations. Monthly matron audits demonstrated from August to September 2021 100% of records checked showed consent was gain for a procedure undertaken.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. A capacity flow chart was included in the casualty card. We saw this was completed where there were concerns about a patients capacity, however, this was not routinely completed for all patients. Monthly matron audits demonstrated from August to September 2021 100% of records checked showed patients requiring a mental capacity assessment and best interests had one.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could tell us what their responsibility was in relation to decision making requirements. Staff made referrals to mental health liaison services where required.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff and managers working in the paediatric area within the Emergency Department demonstrated a good understanding of consent processes for children and young people.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Applications for Depravation of Liberty Safeguards (DoLS) were not routinely completed in the department. Patients requiring a DoLS application had this completed once the patient was admitted to a ward. Patients in the ED had their best interests assessed.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good ↑↑

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were generally discreet and responsive when caring for patients. Most staff took patients into cubicles to complete assessments, undertake procedures or have private discussions. Curtains were used to protect patients privacy and dignity.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. In general, we observed staff interactions being kind and empathic. All patients spoke highly of the care they had received from staff.

Staff followed policy to keep patient care and treatment confidential. Whilst the environment was challenged in space, we observed staff making effort to maintain confidentiality when talking to patients. However, we did observe a medical staff member having a conversation about blood results with a patient in the fit to sit area of the waiting room.

Urgent and emergency services

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

The department lay out did not support staff to maintain privacy and dignity of patients at all times. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients emotional support and advice when they needed it. Patients confirmed staff were caring and sensitive to their emotional state. We observed staff reassuring patients and taking time to interact with them despite being extremely busy.

The dedicated relative's room was unavailable during our inspection as it had been used for other purposes. We observed on one occasion a family of a patient sat in the fit to sit area of the department whilst their relative was in the resuscitation area.

Members of the chaplaincy team also visited patients in departments, providing spiritual care as requested by patients and families.

Staff supported patients who became distressed in an open environment, but there were limited facilities to help them maintain their privacy and dignity. There was no dedicated mental health room or family room to take patients into when they became distressed. Staff made effort to maintain privacy and dignity, but the department did not support this. Following the inspection, the trust told us they intended to refurbish a room suitable for patients with mental health concerns or in distress.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with generally reported they felt involved in their care and decisions. They also told us that most staff were approachable, and they generally felt able to ask any questions they had.

Staff talked to patients in a way they could understand. We observed nursing staff communicating in a way which put patients at ease and could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information on how patients and their families could give feedback on their care was displayed in the department.

Staff supported patients to make advanced decisions about their care. We saw staff made effort to contact and include family where advanced decisions had to be made. Staff told us they would discuss with patients were able.

Urgent and emergency services

Staff supported patients to make informed decisions about their care. Staff told us they provided patients with relevant information to make a decision.

The feedback from the Emergency department 2020 survey test was positive. The trust's emergency departments scored about the same as other trusts in 25 out of 38 questions and lower than others in 13 questions.

Is the service responsive?

Requires Improvement 

Service delivery to meet the needs of local people

The service was managed in a way that met the needs of local people and the communities it served. Managers and staff worked with others in the wider system and local organisations to plan care.

Managers tried to plan and organise services, so they met the needs of the local population. However, they were restricted due to an unsuitable environment, lack of inpatient hospital beds and system challenges. System challenges included poor engagement from local general practitioners, lack of intermediate care beds to discharge patients medically fit and inconsistent information technology systems not allowing joined up working. Leaders worked closely with the commissioners and community providers to find system responses to the capacity issues both in the emergency department (ED) and the wider trust. Trust representatives were active members in regional urgent and emergency care boards. They met regularly with the ambulance service to improve services.

The service had introduced strategies to ensure the patient went to the right place at the right time and to avoid unnecessary admissions. For example, a consultant was placed in the waiting area to support walk in flow, assess suitability for same day emergency care, ensure patients were directed to the most suitable area and oversee the rapid assessment and treatment (RAT) stream.

The percentage of attendances resulting in an admission was consistently higher for Pilgrim Hospital than the Midlands average and the England average from 23 of May to 12 of September 2021. On the 12 of September 2021 the percentage for Pilgrim Hospital was 36.6% compared to the Midlands average of 25.6% and England average of 23.9%. Service leaders recognised further system wide work was required to build on progress in ensuring patients were seen in the right place.

Facilities and premises had significantly improved, however were not always appropriate for the services being delivered. The building and capacity had outgrown the demand. The service had a capital build plan and had made significant efforts to improve since our last inspection. The service had implemented the following improvements:

- COVID pathways had been implemented to enable effective separation of COVID-19, suspected, confirmed and negative.
- A separate and fully functioning paediatric area within the Emergency Department. It was secure access in and out. There was a waiting room, triage room and decorated to a suitable standard.
- A modular waiting area to increase waiting room capacity was implemented with 16 chairs.
- A fit to sit stream implemented in the waiting area with four dedication chairs and in the ambulance stream area.
- An additional triage room meant there could be two triage streams during busy periods.

- Additional resuscitation capacity created in the 'green' COVID-19 stream which could be stepped down. This was used as additional majors' bays at the time of the inspection as the resuscitation facility was not required.
- X-ray room to improve timeliness of x-ray.

Furthermore, the service no-longer cared for patients in the central corridor space. At the time of the inspection the corridor was not in use. Managers told us an escalation procedure was in place which had to be signed off at executive level. Corridor care had only been used once since our last inspection due to having four trauma patients at one time impacting capacity.

There were three cubicles dedicated to a Rapid Assessment and Treatment (RAT) process and additional fit to sit capacity in the waiting room (four chairs) and ambulance streaming corridor.

During our inspection, the waiting rooms were over capacity due to the volume of patients attending the department. There were periods where ambulances could not be offloaded due to the department being full. Exit blockages prevented admissions. Access to specialities to review patients within ED sometimes impacted exit block as did capacity issues with the integrated assessment unit (IAU).

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. This was applicable to the integrated assessment unit.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. However, there was limited space in the department to accommodate wheelchairs, bariatric equipment and hospital beds.

The service relieved pressure on other departments when they could treat patients in a day. Patients were not admitted for an overnight stay unless this was required, and admission rates were monitored. A frailty team was in place to provide additional support to frail elderly patients who could go home with extra support instead. The service utilised fit to sit areas where appropriate to take the pressure off majors' cubicles. Pathways were in place to ambulatory care.

Meeting people's individual needs

The service was not always inclusive and took account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. For example, a patient with a learning disability waited on an ambulance for a prolong period (152 minutes) and then moved to the clean procedure room for assessment. The patient had become increasingly distressed and the clean procedure room was not considered to be a suitable environment for a patient in distress or with a learning disability. We found staff lacked situational awareness in managing the patients' individual needs. Staff used the room to ensure the patient was assessed as they had been on the ambulance for a prolonged period but failed to recognise the impact of the environment.

The department was not designed to meet the needs of patients living with dementia. Most areas of the department were bright, busy and noisy which some groups of patients might find distressing, and there were very few side rooms where quieter care could be provided.

Staff did not always understand or apply the policy on meeting the information and communication needs of patients with a disability or sensory loss and did not have access to communication aids to help patients become partners in their care and treatment. Staff were not aware of communication aids that could be used for patients who had communication difficulties. Staff told us they could access sign language.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to translation services.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Most food offered in the ED was sandwiches, plus toast and cereals at breakfast time. Hot foods had been introduced for patients waiting for long periods in the department. Staff said they had access to other food types and were able to meet patient's individual preferences.

Access and flow

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients fell below national standards.

Whilst improvements had been made, patients could not always access emergency services when needed and receive treatment within agreed timeframes and national targets. Systems had been implemented to increase triage capacity in terms of additional rooms and flexibility to move staff to triage at busier times. The pre-hospital practitioner (PHP) role had improved to ensure all ambulance conveyances were triaged on arrival. From April to September 2021 an average of 91.7% of adults and 91.5% of paediatrics were triaged within 15 minutes of arrival.

However, there were delays in patients being transferred from the ambulance to the emergency department. On day one of our inspection we observed six ambulances waiting at 2.41pm with the longest wait approximately three hours. The department was above capacity with 51 patients in the department. Whilst processes were in place to improve the safe care of patients waiting on ambulances, patients had to wait until there was space in the department to be assessed and treatment commenced. For example, at 9am on day one of our inspection, there were 38 patients in the department with 20 waiting to be admitted. There were no beds identified for the patients which impacted on the ability to bring new patients into the department in a timely manner. We were advised at 11am three patients had been transferred to a ward area, leaving 17 patients still waiting for a bed.

The Royal College of Emergency Medicine (RCEM) recommends patients wait no more than one hour from time of arrival to receiving treatment. The trust consistently failed to meet this standard. However, the service had consistently met its internal target of 50% to be seen within 60 minutes based on its medical staffing model. From March 2021 to September 2021 the average percentage of patients seen within 60 minutes was 56.4%. Performance has worsened slightly over this time as demand for the service has increased. The average time from arrival to first seen by a doctor was 93.29 minutes in July, 90.27 in August and 103.30 in September. The service had implemented systems to mitigate risks such as a consultant being placed in the waiting areas to reassess patients waiting more than 60 minutes.

Compliance with the RCEM guidance to see, treat, admit or discharge within a four-hour target was not always met. From February to August 2021 the trust's percentage of patients waiting over four hours from decision to admit to admission was among the top three in the Midlands. In August 2021, 55% of patients waited between 4-12 hours to be admitted to a ward from the point of decision to admit. This was against a national average of 26%. Furthermore, in September 2021, 71 patients waited more than 12 hours in the emergency department from the decision to admit time.

Urgent and emergency services

During our inspection two patients were identified as waiting more than 12 hours. Rapid reviews were completed and no harm was identified. One patient was delayed for medical reasons and the second due to a delay in facilitating a transfer. On the second day of our inspection the performance against the access target was reported to be 52% with 56 breaches.

Managers monitored waiting times to ensure people with the most urgent needs had their care and treatment prioritised. The emergency physician in charge (EPIC) and NIC undertook two hourly huddles where they reviewed all patients waiting and undertook assessments to ensure patients were offloaded from ambulances and moved to a safe area in the department according to acuity.

Escalation processes were in place to allow the ED to highlight problems with access and flow quickly. The nurse in charge (NIC) completed an emergency department risk tool hourly which used information such as number of patients waiting at different part of the system, staffing levels and acuity to assign a risk level. There were clear escalation processes as a result of the risk rating which were reported into capacity meetings.

Patients details were added to electronic system which provided managers with oversight of the department. This was used when reviewing patients. A local ambulance service electronic board was visible in the department to show times crews arrived, inbound ambulances and expected arrival times so staff are aware.

The PHP was in place 24 hours to ensure rapid and safe handover of ambulance patients. Any ambulances that were not immediately offloaded were escalated to the department site manager.

A full capacity protocol was in place which was sensitive to departmental pressures as identified through the ED risk score. The trust used the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). The OPEL level was regularly communicated within the trust and to stakeholders to ensure the wider health and social care systems were aware of the current access and flow status. We observed staff escalate appropriately. For example, we observed the triage nurse escalate concerns about waiting room capacity to the NIC who updated the risk tool and clinical site manager.

During our inspection the department had declared a level three OPEL, with level four evoking the maximum system supports possible. Managers told us whilst at level three they were implementing level four actions.

Managers and staff worked to make sure patients did not stay longer than they needed to, however they were impacted by wider hospital and system issues. A fit to sit area was implemented so patients who were likely to be discharged the same day could be then either discharged or transferred to ambulatory emergency care of SDEC.

Managers told us they had improved working relationships with specialities to increase timeliness of speciality reviews. However, managers told us this was a challenge due to the medical workforce pressures and lack of engagement with surgical speciality caused delays. When under considerable pressure the ED department implemented its STRAP (short term rescue accident and emergency protocol) which meant a decision could be made to request speciality s to in reach into the department get assess, review and transfer patients to their wards.

Medical patients requiring admission went from the ED to the integrated assessment centre (IAC) which was a 12 hour stay ward to decide whether they would require admission. If further diagnostics or treatment was required, they would then go to the short stay ward for up to 72 hours. On the morning of day one of our inspection there were 20 patients with a decision to admit and waiting for a bed, yet the IAC was at capacity. Therefore, patients had to wait for beds to become available which created a bottle neck. For example, we spoke to consultants who identified there were two

patients who required a surgical bed. They were aware there were two surgical bed available, however, the process was for patients to go to IAC first where they would receive a speciality review. This meant patients had to wait for long periods on trolleys in a busy department before a bed became available. Consultants were unable to admit straight to base wards. Senior leaders told us this was because the staffing template did not support direct referrals from ED.

The number of patients leaving the service before being seen for treatments was in line with the midland and England average. The percentage of patients who left before being seen was close to the Midland regional average and England average for most of the two-year period from August 2019 to July 2021. July 2021 saw an increase in patients who left before being seen to 5% but this is now below the Midland average of 5.8% and England average of 5.6%.

Managers and staff worked to make sure that they started discharge planning as early as possible. We observed the frailty team attended the ED to assist with discharges. We observed consultants reviewing patients on ambulances with a plan to discharge where safe. There was a trust wide initiative to free up hospital beds earlier in the day and to improve patient flow out of the ED. Daily calls were held with partner organisations in order to free up hospital beds and obtain access to continuing care for patients who required it. Daily bed meetings occurred three times a day to set actions for identifying and reviewing patients ready for discharge. Any blockages were addressed and where required senior management intervention.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff sought advice and support in discharging from the mental health liaison team. We observed a patient waiting for a mental health assessment prior to being discharged to ensure the discharge was planned appropriately to the patient's needs.

Staff supported patients when they were referred or transferred between services. The service implemented a transfer checklist which we saw was in place for six records we reviewed. This ensures all relevant information about the patient was shared with the incoming ward.

Managers monitored patient transfers and followed national standards. Children and young people were transferred to other hospitals using recognised safety standards which staff understood.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff could describe the complaints process. Staff tried to resolve any issues at the time in the first instance and report it to the nurse in charge. Staff knew how to signpost to the trust complaints process. From April 2021 to September 2021 the serviced received a total of 65 complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. At the time of the inspection, the service had eight open complaints, one of which was 17 days overdue. On average responses were sent to complainants within 44 days of receipt. This included a review by the complaints manager, divisional and executive sign off. This is in line with the trust complaints policy which states complaints will be responded to within 25 to 50 working days dependent on the complexity.

Urgent and emergency services

Managers shared feedback from complaints with staff and learning was used to improve the service. An action log was in place to keep track of learning actions and implementation dates. Learning and themes were shared through divisional governance meetings. Staff received feedback in daily huddles and in the departmental newsletters.

Staff could give examples of how they used patient feedback to improve daily practice. For example, communication with patients and relatives was a common theme. The service had introduced regular patient comfort rounding which provided staff with an opportunity to update patients. The service had also recently introduced regular hot food service on the back of feedback for patients who experience long waits in the department.

Is the service well-led?

Requires Improvement 

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Improvements were observed in clinical leadership. Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. The urgent and emergency care (UEC) service sat in the medicine division and was led by a divisional clinical director, a divisional managing director and divisional nurse. However, at the time of the inspection the divisional nurse position was vacant, and recruitment was underway. Urgent and emergency care leadership consisted of a clinical lead, a general manager and deputy divisional nurse who covered all three sites across the trust. At Pilgrim hospital the nursing team was led by a matron and a band 8a senior sister. Both had completed leadership training.

At our last focused inspection, we found leaders did not have the skills and abilities and gaps in clinical leadership had not been addressed. We found improvements had been made following our last inspection. For example, we found:

- A divisional director had been recruited to oversee and lead the medicine and urgent care division.
- A clinical lead was in post with overall responsibility for UEC across the trust and there was a clinical director in post.
- The emergency physician in charge (EPIC) role had improved since our last inspection. Training in leadership had been provided to consultants undertaking the EPIC role which covered leadership, development of situational awareness, escalation processes, rapid handover protocol, full capacity protocol and short-term rescue protocol (STRAP). EPIC training sessions were held monthly.
- The service had recruited into band seven pre-hospital practitioner (PHP) posts. This improved management of flow in the department and oversight of safety of patients.
- The service had improved its joint working between the EPIC and Nurse in Charge (NIC) role. We observed greater team work along with operations teams and the PHP to improve flow and quality of care.

The service had strengthened local leadership by recruiting into band seven sister posts. Each band seven was assigned a lead role. For example, safeguarding, IPC, flow, sepsis and clinical education. Whilst the posts were recruited into, the post holders had not yet been able to complete the leadership elements of their role due to increased demand in the department, a junior workforce and requirement to work clinically. This meant leaders including the matron and senior sister were working down to ensure the service was safe.

Staff in senior leadership positions had completed leadership training. For example, the matron and senior sister had completed Royal College of Nursing (RCN) leadership courses. New band seven nurses in post were intended to complete the RCN course and had completed leadership sessions internally.

The Royal College of Paediatrics and Child Health recommends every emergency department treating children must be staffed with a Paediatric Emergency Medicine (PEM) consultant with dedicated session time allocated to paediatrics. This was not in place at Pilgrim hospital. Leaders told us there was a consultant who took a lead with paediatrics and there was always a consultant on duty with paediatric competencies. However, this did not meet the standards and we were not assured there was robust leadership of the paediatric area within the Emergency Department at Pilgrim hospital.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address it. During our inspection we interviewed the triumvirate and local leadership. They were able to tell us about current challenges and how they are addressing them. For example, medical staffing was a challenge. Leaders had a recruitment plan which meant all vacant post would be filled the beginning of 2022. Junior doctor training had opportunities for career escalation within the department. The service had a plan to sustain medical staffing by developing the certificate of eligibility for specialist registration (CESR) programme within the service. Furthermore, there were plans to apply for teaching status.

Leaders were visible and approachable. Staff told us the senior leadership team were visible. Senior managers including divisional directors and the deputy divisional nurse undertook regular walk rounds in the department. Managers told us they would support the day to day operation at times of peak demand.

The senior sister was visible and had a good relationship with staff.

Engagement workshops took place following our previous inspection with the aim of improving the working relationship between clinical, nursing and operational leads.

Vision and Strategy

The service vision was integrated into the trust wide vision which outlined what it wanted to achieve and a strategy to turn it into action. The trust vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service did not have a specific urgent and emergency care vision and set of values. However, leaders told us they were aligned to the trust strategy. The trust vision was to provide excellent specialist care to the people of Lincolnshire and collaborate with local partners to prevent or reduce the need for people to be dependent upon services. The trust had five key values underpinning its strategy including: patient-centred care, compassion, respect, excellence and safety. During our inspection we saw examples of staff enacting these values.

The trust implemented a five-year integrated improvement plan started in 2020 aimed at delivering the trust strategic objectives. This included actions in relation to the emergency departments (ED) such as medical recruitment plans which had proved successful. Furthermore, there were workstreams that would impact ED such as becoming a university hospital, enhancing data and physical capacity, improving the environment, developing the workforce and well-led services. During our inspection we saw the impact of some of these including improving the environment and improved workforce planning.

Urgent and emergency services

The trust had a five-year clinical strategy and delivery plan started in 2019. It contained a brief strategy for urgent and emergency care services to:

- ‘Maintain A&E /Emergency Department services at both Lincoln and Pilgrim Hospitals, and to add an Urgent Treatment Centre at both sites’.

Other key deliverables identified were to establish a separate paediatric department at Pilgrim, extend the resuscitation capacity and development of urgent treatment centres. During our inspection we saw these deliverables had been completed and work continued to embed the processes. However, we were unclear what the key objectives were and actions to develop were moving forward. Managers could however describe the plans in the form of a new build and workforce development

The trust worked alongside health and care partners in Lincolnshire to ensure the clinical strategy was aligned with their strategic direction for the county wide health and care services. The system delivery lead chaired an urgent and emergency care delivery board that ULHT attends.

Staff could describe the trust vision and values.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt generally supported, respected and valued. Most clinical staff we spoke to spoke highly of the support they received from line managers and other leaders. Staff told us morale was low following the previous inspection, but this had significantly improved. Junior doctors spoke highly of the support and guidance they had received from consultants. However, some clerical staff felt their role was not as valued as they were not included in a salary uplift as were clinical staff. Despite this they were positive about the improvements made to the service.

Staff generally felt positive and proud to work in the organisation. The culture encouraged openness and honesty at all levels. Most staff described how much the service had improved and one commented it was the best it had ever been for them as a place to work. Improved staffing levels and reintroduction of students was cited as reasons staff felt more positive.

The culture was centred on the needs and experience of people who use the service. Leaders completed regular walk rounds in the department to speak to patients about their experience. Matrons spoke to 10 patients as part of their assurance audits. Staff were supportive of service changes as they knew they benefited the patient. For example, the introduction of two hourly rounding was effectively implemented as staff knew this would make the service safer for patients.

Managers took action to address behaviour and performance consistent with the vision and values. During our inspection, managers acted swiftly to address feedback provided to them. For example, feedback was given to a staff member who had not completed an assessment. This was done at time and with a learning approach to positively support improvement. Managers told us they sought support from human resources for more formal management.

There was an emphasis on the safety and well-being off staff. Matrons included staff wellbeing checks in monthly assurance audits. Senior leaders provided staff with opportunities to feedback about how they are feeling. We saw staff breaks were encouraged and managers told us they monitored the number of additional shifts staff booked. The trust wellbeing team had attended the department to support wellbeing of staff. The matron had introduced coffee, cake and chat sessions for staff.

There were co-operative, supportive and appreciative relationships amongst staff. Staff and teams worked collaboratively. Staff described improvements in the collaborative working between different roles. For example, there was a mutual appreciation of roles between medical and nursing staff and we observed good team working. Staff told us managers helped when the service was under pressure.

Governance

Leaders operated effective governance processes; however, we were not assured there were clear lines of governance in relation to the paediatric area within the Emergency Department. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services were generally clear. Local departmental speciality governance meetings were held as well as divisional business and clinical meetings. Clinical and business governance meetings were regular, well attended and covered a wide range of issues. For example, operational performance, complaints, incidents, training, safety alerts and mortality and morbidity meeting outcomes. The minutes were shared with staff and available electronically for anyone unable to attend. Minutes showed clear outstanding actions and included an action owner along with an expected timeframe for completion.

However, we were not assured there were clear lines of governance in relation to the paediatric area within the Emergency Department. We did not see evidence of regular updates in governance meeting minutes we reviewed.

All levels of governance and management function effectively and interact with each other appropriately. Local governance meetings fed into a divisional cabinet meeting which had oversight of safety and quality of the service. A divisional score card with several metrics including finance, HR, people, quality, performance was in place. This was reported by divisional leaders to executives and trust board through performance review meetings and the quality and safety oversight group.

Staff at all levels were mostly clear about their roles and understood what they were accountable for, and to whom. Although it was recognised the service had introduced a new tier of band seven sisters who had not fully embedded at the time of the inspection due to pressures to work clinically.

Processes were in place to ensure relationships with partners were managed effectively. Standards operating procedures (SOPs) were in place with the local ambulance service and urgent treatment centre. These were reviewed regularly. For example, there were routine and regular meetings with the local ambulance service as well as extraordinary meetings to address concerns of long ambulance waits. The service attended a monthly Lincolnshire providers UEC governance meeting. This was an opportunity to assess practice against the SOPs and raised and concerns to improve joint working. Minutes contained case discussions to explore the most appropriate place for patients to be treated.

The mental health liaison nurse attended departmental governance meetings.

Urgent and emergency services

Management of risk, issues and performance

Risks on the risk register were not always effectively managed to reduce their impact. Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.

Divisional risk register review and oversight processes were not always effective. It was not always clear what the risk was, when the risk was added, and it was unclear who had oversight of the risk registers. Local leaders did not have ownership of the risk register therefore there was the potential for departmental risks to be missed.

Whilst most managers could describe risks, they could not always tell us what the risks were on the risk register. Whilst we saw risk registers had been updated, we did not see how the reviews linked into existing governance structures. For example, we reviewed the Pilgrim site ED speciality governance meeting minutes for 11 August 2021. There was reference to the risk register in terms of a discussion about the best way to present to the CQC, however, there was no discussion about risks and actions. Furthermore, there was no evidence the risk register was discussed at the 15 July 2021 UEC clinical business unit governance meeting despite this being an agenda item.

Day to day identification and management of risk was done using the emergency department risk tool. Processes were in place to escalate with clear actions to be taken dependent on the level of risk. Safety issues were reviewed throughout the shift by a nurse in charge who completed an assurance checklist on each shift which covered staffing, communication of safety messages, an audit of patients, controlled drug checks, infection prevention and control checks, equipment checks and key performance indicator updates. This was regularly updated and used to address an issue with performance in real-time.

Monthly matron assurance audits were completed which provided an overview of quality, performance, staffing, patient experience and staff wellbeing. This along with departmental performance indicators was discussed with the deputy divisional nurse during confirm and challenge meetings and pulled together into a score card.

Performance in national audit outcomes were not effectively integrated into the governance structures to ensure management oversight. There was a lack of interface between national patient outcome performance and internal quality indicators in working together to improve overall performance. For example, we saw limited evidence of consideration of national patient outcomes and monitoring of improvements plans in governance meetings.

There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken in the event of a utilities failure or major incident. For example, during the inspection the electronic systems went down, and staff quickly implemented actions in their business continuity plan to manage the risk and maintain oversight of the department.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure but not always integrated.

The service had an integrated score card which demonstrated performance across all areas of the service. Data was collected from various systems including electronic, audits, feedback from staff and patients. The information was analysed to form an assessment of risk and used to monitor performance overtime which was reported to the board. Local managers met with more senior managers regularly to set actions in response to these.

Urgent and emergency services

Clear and robust performance measures were used to assess quality and safety. Managers and staff knew what these were in relation to emergency department standards and patient care and safety. We saw the service used data to monitor performance against standards in real-time.

Electronic systems were used effectively to provide local leaders with oversight of the department. Large screens in the department provided staff with an electronic queue meant they could see where all patients were. This included vital information about numbers in the department and at which point of their journey. It also allowed nurses and consultants in charge to identify deteriorating patients and ensure they have been appropriately escalated.

The information systems were secure. The systems were integrated with the wider hospital but not always with partner organisations. For example, where the ambulance service was holding patients and monitoring observations, this was not on the service electronic system. This meant consultants and nurses in charge were reliant on being verbally updated by ambulance staff and pre-hospital practitioner of any signs of deterioration.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service used people's views and experiences to shape and improve the service. For example, feedback was sought from patients' relatives and staff to formulate the integrated improvement plan. The feedback helped leaders develop key priorities and decide which to prioritise. The Emergency Department (ED) gathered patient feedback through the Friends and Family Test (FFT). The service participated in the annual emergency department survey and used feedback to improve. For example, the service used feedback to introduce hot food rounds for patients waiting in the department for long periods. We saw messages to staff in monthly departmental newsletters requiring staff to act in response to views of people using services.

Staff were actively engaged, and their views were reflected in the planning and delivery of services. For example, feedback was sought from staff to help shape the future new build of the emergency department due to start in 2022. During our inspection, staff were asked to complete an on-line survey to provide feedback and suggestions about improving the paediatric area within the Emergency Department. General feedback from staff was they felt senior management were more interested in their views providing them with more opportunities to feedback than previous.

The service worked collaboratively with external partners to build a shared understanding of challenges within the system. Regular meetings were held with key partners including the local ambulance service and urgent treatment centre providers.

The service also worked collaboratively with other departments. For example, feedback had been sought from children and young people services when designing and decorating the new paediatric department. Leaders were passionate about making it a child friendly environment. Staff were very proud of the improvements made.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Urgent and emergency services

Systems and processes were in place to monitor performance. Outcomes and learning were shared with staff to improve understanding and set actions for improvement. The service had improved oversight of their performance, took action resulting in improvements in performance. For example:

- The triage process and performance had improved.
- Identification and management of deteriorating patients had improved.
- Two hourly intentional rounding had resulted in improvements in patients being provided with adequate nutrition, hydration and repositioning where required.
- Improvements were noted in the timeliness of pain assessments and administering analgesia.
- Twelve-hour trolley waits had generally reduced.

The service had made significant service improvements since our previous inspection. For example:

- The service acted following our previous inspection to stop central corridor care of patients being normal practice.
- Training had been provided to staff to improve clinical leadership. Oversight of the department and collaborative working between nursing and medical leaders was observed as a significant improvement.
- Action had been taken to improve staff recruitment and retention resulting in reducing vacancy rates. The service commenced the certificate of eligibility for specialist registration (CESR) to recruit doctors which enables doctors from abroad to go on the specialist register held by the General Medical council (GMC) as a consultant.
- Improvements were observed in the oversight of skill mix for both medical and nursing staff by creating rotas with skills required filling.
- Departmental refurbishments had improved the environment in terms of safety and patient experience. For example, the implementation of a paediatric area within the Emergency Department, expanding resuscitation space, improving the waiting area and fit to sit areas.
- Improvements in the department included regular quality audits on patient care and safety. For example, sepsis audits, compliance to escalation of sick patient protocols and mental health patient triage and assessment documentation. Some of these improvements were instigated following our previous inspections. Results from the audits largely showed an upward trend in compliance.

Managers were able to tell us areas for further improvement such as development of governance and risk register oversight, continued focus on ambulance waits, continued review of medical staffing levels to improve the number of patients seen and treated within 60 minutes of arrival. The paediatric area within the Emergency Department was also seen as a further area for development in terms of governance and staffing levels.

Maternity

Good ↑

Is the service safe?

Good →←

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women and babies at risk of deterioration.

Staff used the Modified Early Obstetric Warning Score (MEOWS) and Paediatric Early Warning Score (PEWS) which are nationally recognised tools to identify women and babies at risk of deterioration and escalated them appropriately. Records showed and we observed timely and appropriate responses to rising early warning scores, ensuring women and babies were escalated appropriately in the event of clinical deterioration.

Staff completed risk assessments for each woman on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk factors included; blood clot risk, carbon monoxide risks and a general risk assessment relating to whether the pregnancy was high or low risk. These risk assessments were recorded in both electronic and paper records, and were used by community and acute staff. This ensured that staff always had access to this information in the event of an emergency. We saw this was effective as staff used these paper records when the electronic records system was unavailable during part of our inspection.

Staff knew about and dealt with any specific risk issues. For example, we saw when women were identified as having a risk of developing blood clots, appropriate action was taken to reduce this risk.

In line with national recommendations, a 'fresh eyes' approach to cardiotocography (CTG) interpretation was in place for those women who required continuous CTG monitoring. A CTG measures a baby's heart rate and monitors the contractions in the womb (uterus). Fresh eyes checks were performed every hour by a second staff member during continuous fetal monitoring. This provided a safety net to reduce the risk of misinterpreting a CTG reading. Records we reviewed showed appropriate monitoring, interpretation and escalation of CTG readings.

Staff completed a mental health screen on all women and arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Every woman's' risk of domestic violence was also assessed during every appointment when this was appropriate. Risks associated with mental health and domestic violence were clearly recorded in the patient records and flagged on the electronic patient record system. Referrals for specialist support were made for women who were at risk of or experiencing domestic violence.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health.

Records showed that staff consistently performed swab counts in theatre and completed the World Health Organisation (WHO) checklist in line with National Patient Safety Agency (NPSA) guidelines. The WHO checklist is a global initiative that was designed and implemented to improve surgical safety. Regular WHO checklist audits were undertaken and recorded electronically which showed 100% compliance with the WHO surgical safety checklist.

Maternity

Shift changes and handovers included all necessary key information to keep women and babies safe. Staff discussed all inpatients at the midwifery handover and the multi-disciplinary team (MDT) handover meetings. This ensured midwives and medical staff had access to key information to keep women and babies safe when handing over their care to others.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep women and babies safe. Staffing data for September 2021 showed the service had -5% medical and -2.47% midwifery and support staff vacancies. This meant the service had no vacancies.

Staffing rotas for August and September 2021 evidenced that actual staffing numbers did not always meet planned numbers. Staff told us this was due to sickness. However, staff also told us that if patient acuity meant any staffing gaps needed to be filled to ensure the safety of women, those shifts were always covered. Cover was provided by staff picking up additional shifts, managers and specialist midwives. Trust data showed that one to one care during labour was provided to women 100% of the time between November 2020 and October 2021.

Managers calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. The birth rate plus tool was used to measure and review acuity and in workforce planning. At the time of our inspection, the service (which included Pilgrim Hospital and Lincoln County Hospital) was staffed based on the trust's Birth rate Plus recommendations of 2017. Managers had since completed a birth rate plus review which recognised an increase in acuity of women admitted to the service. This report was received by the trust in March 2021. This review identified a shortfall of 3.51 whole time equivalent (WTE) midwives. A bid for the funding for the posts was in progress.

A continuity of carer (CoC) review had also been completed. CoC is an approach that aims to provide consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey. The trust had submitted a bid to fund an additional 8.69 WTE staff to support the rollout of CoC to 35% of women.

The ward manager could adjust staffing levels daily according to the needs of women. Staff reviewed acuity every four hours which meant adjustments to staffing could be made in response to an increase in acuity. Staff told us that when acuity increased, additional staffing was provided to keep women and babies safe.

Consultants and anaesthetists were always available. This included the provision of out of hours on call cover which staff told us was always provided in a timely and responsive manner.

Managers made sure all staff had a full induction and understood the service.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They reported serious incidents and near misses in line with trust policy.

Maternity

Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong.

Staff told us that managers provided debriefs and support after any serious incident.

Managers shared learning with their staff about serious incidents that happened at the service and elsewhere within the trust. Learning from incidents was emailed out to all staff and read out in every staff handover which the staff referred to as a 'newsflash'. We observed the newsflash being read out at the handovers we observed.

Staff met to discuss incident feedback and look at how they could improve patient care. For example, maternity staff reviewed CTGs with consultants and learned from incidents where CTG interpretation was incorrect. This learning took place during weekly CTG meetings. This showed the service had learned from previous serious maternity incidents where CTGs had been incorrectly interpreted to prevent recurrence.

The service had no maternity never events in the 12 months leading up to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Staff also worked with external agencies to ensure learning from incidents was shared. The service referred relevant incidents to the maternity Healthcare Safety Investigation Branch (HSIB). Staff used recommendations from HSIB reports to improve patient safety.

Is the service effective?

Good ↑

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed 11 clinical policies relating to the maternity department. This included; diabetes in pregnancy, hypertensive disorders in pregnancy and sepsis guidance. These were all up-to-date and reflected best practice guidance and national standards.

Managers used audits to check that staff followed agreed clinical guidance. Audits appropriately identified areas of compliance and areas for improvement. Audit areas included; assessment and management of sepsis, fetal monitoring and catheter care.

In accordance with national guidance, staff routinely referred to the psychological and emotional needs of women. We observed nursing and multidisciplinary handover meetings which evidenced this.

Maternity

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers gave all new staff a full induction tailored to their role before they started work and staff were supernumerary in their areas until they became familiar with the service's environment and processes.

Newly qualified midwives undertook a preceptorship programme and competency assessment. They were supported throughout the programme and met regularly with their supervisor.

Managers supported staff to develop through yearly, constructive appraisals of their work. This ensured that staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. At the time of our inspection, 92% of medical staff, 72% of registered nursing staff and 81% of support staff had received an appraisal. Nursing and support staff appraisal rates were below the trust target of 90%, however plans were in place to increase appraisal rates and staff and managers had been contacted to remind them to engage in the appraisal process.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us team meetings had become more accessible as they had moved to virtual meetings.

Specialist training for staff specific to their roles was provided. For example, training in fetal monitoring was provided, this included CTG training. The trust's CTG training target was 90%. Training data for September 2021 showed that 84% of midwives and 88% of consultants had completed this training. Training data for trainee doctors was much lower at 10% but this was because trainee doctors had recently rotated and their training was in progress. All staff had received a reminder to complete this training in order to improve compliance rates. Support staff also told us they were able to access specialist training for their role. This included attending breastfeeding workshops to enable them to offer practical and emotional support to women.

Staff participated in multidisciplinary training and utilised external resources including those produced by the Practical Obstetric Multi-Professional Training (PROMPT) charity. PROMPT is an evidence-based multi-professional obstetric emergencies training package that has been developed for use in local maternity units. Staff we spoke to confirmed they participated in MDT training and that the service had adapted during the pandemic and moved to virtual PROMPT training. PROMPT compliance data from November 2021 showed that 86% of midwives and 59% of medical staff had completed this training. The trust had plans to achieve their 90% target compliance rate by March 2022.

Private social media platforms were also utilised to make training more accessible to staff. For example, a social media live video showing staff how to don and doff personal protective equipment had been shared that staff could replay at a time convenient to them.

Managers identified poor staff performance promptly and supported staff to improve. Examples were shared that demonstrated this.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Maternity

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed these meetings and saw that risks were appropriately discussed and information was shared in a manner that promoted continuity of care.

All the staff we spoke with spoke positively about the multidisciplinary working on the wards, within the wider hospital and in the community. We saw maternity staff worked effectively with other teams within the hospital. This included working with surgical teams and paediatricians.

Staff worked across health care disciplines and with other agencies when required to care for patients. Records showed that staff referred women to other agencies such as; safeguarding, social care and mental health services.

Is the service well-led?

Good ↑

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The senior leadership team within maternity were mostly new to post since our last inspection. Staff described this as refreshing and positive. The managers and leaders we spoke with displayed enthusiasm and drive to improve maternity services for the women, babies and staff.

Managers had the right skills to perform their roles effectively. Managers and senior staff told us that management level training was provided to ensure their leadership skills continued to be developed and improved.

Managers and senior staff understood the priorities and issues the service faced. This included the poor estates and facilities within maternity which they escalated appropriately. Managers and senior staff escalated any safety issues with the estates and facilities promptly to promote the safety of women and babies.

Managers and senior leaders displayed the qualities required for effective leadership. This included being approachable and accessible. Staff told us and we saw that managers and senior leaders were visible in all the areas we visited. All the staff we spoke with told us they felt supported and valued by their managers.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We saw there was a positive open culture as staff spoke with the inspection team openly and honestly. Staff told us there was a no blame culture and they felt able to raise concerns with their managers and freedom to speak up guardians were accessible if required.

Staff morale in the areas we visited was particularly positive and local initiatives were in place to promote wellbeing and morale. For example, staff on the maternity ward could share positive messages and feedback to their colleagues by leaving messages in a 'Ta jar'. These messages were then shared directly with individuals which made them feel respected and valued.

Joint meetings and training sessions were facilitated within this service and the service at Lincoln County Hospital site. This promoted joint working and learning between the two maternity units at the trust.

Staff promoted equality and diversity within the service. Staff told us and we saw that many of the women cared for within maternity services were from minority groups. Staff understood and used the trust's systems to ensure these women and their families were able to access appropriate care.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Senior leaders from maternity services attended monthly cross site Maternity and Neonatal Oversight Group (MNOG) meetings. The purpose of the MNOG was to have oversight of maternity and neonate services to monitor if these services were safe and in line with national safety and quality standards. The group discussed key topics such as; the maternity and neonatal monthly safety assurance report and monitored the progress and effectiveness of the local maternity improvement plan. The maternity and neonatal quality dashboard which included incidents and other safety data was also scrutinised by senior leaders and external stakeholders in the MNOG meetings. Minutes of these meetings showed that the agreed terms of reference were followed, safety and quality concerns bought to the groups were appropriately acted upon and any improvement actions were appropriately followed up.

Stakeholder feedback was discussed at MNOG. This included stakeholders such as; NHS England and Improvement and patient groups.

The MNOG fed into the trust's Quality Governance Committee (QGC). Minutes of MNOG showed that areas of concern were escalated to the Quality Governance Committee and to ensure any identified risks were appropriately captured. The QCG then fed into the board to ensure they had a regular overview of quality, safety and performance relating to all services at the trust, including maternity. Minutes from trust board meetings evidenced this.

The maternity service had a non-executive director sponsor who was the services named maternity and neonatal safety champion. This sponsor attended the MNOG meetings on a regular basis.

Staff told us that mortality and morbidity reviews were regularly completed to review and learn from deaths, incidents of sepsis and other adverse incidents. However, records did not always evidence the discussion and outcomes of these meetings. The trust were aware of this and had a plan in place to address this. These reviews were not cross site meetings, therefore this was a missed opportunity to have cross site discussions and learning from deaths and other adverse events.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Maternity

A monthly maternity and neonatal quality dashboard was produced. Items covered included national safety standard performance data, such as; 10 Steps to Safety performance data (a national maternity incentive scheme used to improve safety) and saving babies lives performance data (a nationally recognised care bundle aimed at reducing perinatal mortality). Other performance data was also included in this report, including; incidents, patient feedback, complaints and staffing training compliance. Senior leaders told us this provided key information to enable them to have effective oversight of quality and safety within the division.

The service was working from a joint maternity and neonatal improvement plan. This plan set out how the service planned to improve safety, leadership and patient experience. Each recommendation and action within the plan had been risk assessed and rated to enable leaders to establish if improvements were embedded, on track or behind in terms of performance.

We found that risks were appropriately identified and managed. Identified organisational and patient safety risks were recorded on the service's risk register. Each risk was assigned a risk score and level based on its severity and review dates were set and met. For example, staff had identified that paper CTG readings faded over time which meant there was a risk of accurate records not being maintained. This had been recorded on the risk register and appropriate mitigation plans were in place while a long-term solution was agreed. Minutes of governance meetings evidenced that the risk register was discussed on a regular basis which showed there was senior management and board level oversight and management of risk.

Each area's top three risks were also shared to staff through the use of governance boards which meant staff were aware of the risks and the mitigation plans in place to address these risks.

Plans and procedures were in place to enable staff to manage emergency situations such as baby abduction and sudden increases in acuity. Staff confidently explained how they would react to these situations in line with agreed plans and procedures.

Managers told us that staff performance issues were addressed in line with the trust's performance and disciplinary policies and procedures.

Minutes of these reviews clearly stated learning actions, including who was responsible for sharing this learning.

Medical care (including older people's care)

Good ↑

Is the service safe?

Good ↑

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trusts target for mandatory training was 90%, the average completion across all the courses for medical wards was 82%

Nursing staff received and kept up to date with their mandatory training. Face to face modules of mandatory training had been reduced during the pandemic. The division had a plan in place to increase this training as the pressure of the pandemic decreased. The trust aimed to be back to 90% by the end of November 2021.

During the inspection, bank staff across the trust reported that they did not always feel supported with their mandatory training and having time to complete it. This was raised with the trust and they provided us with assurance that they were looking into mandatory training for bank staff and putting processes in place to support this.

Medical staff received and kept up to date with their mandatory training. At the time of our inspection the completion rate for medical staff mandatory training across the medical wards was 85%.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules included key areas relevant to emergency department staff such as: health and safety, fire safety, patient moving and handling, infection prevention and control, equality and diversity, information governance and basic life support.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. Staff completed this training once every three years, the compliance rate for Mental Health awareness training at the time of our inspection was 90% and dementia awareness was 91%. At the time of our inspection the trust were in the process of starting training on learning disabilities and autism and hoped to have this started by December 2021.

Managers monitored mandatory training and alerted staff when they needed to update their training. The trust had reports that could be collated to show compliance with mandatory training at different levels and this was monitored through the trust's governance structures. However, ward managers we spoke with would like direct access to training systems for their areas in order to monitor and action mandatory training needs of their teams on a more regular basis.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

All staff received training specific for their role on how to recognise and report abuse. Staff completed different levels of safeguarding mandatory training according to their roles. The trust target was 90 %. Whilst the trust target had not been achieved across all levels, the trust aimed to be back to 90% by the end of November 2021. All staff we spoke with could explain how to recognise and report concerns related to adult and children's safeguarding.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff could describe caring for patients with protected characteristics and how to keep them safe.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could describe how they had worked with other organisations to ensure patients were protected from harm. Staff told us how they had put measures in place to ensure patients were protected from harm and had their individual wishes listened to. Processes for safeguarding had been strengthened and simplified in order to ensure consistency in referral pathways.

The safeguarding team completed monthly safeguarding audits to assess the quality of safeguarding and DOLS referrals. These were reviewed at a safeguarding operational group. Any areas in need of extra training or specific support were identified in order that targeted support can be provided within an immediate time frame. Good practice was also discussed and disseminated for ongoing learning and development. Monthly audits of safeguarding and deprivation of liberty safeguards (DoLS), identified between January and September 2021 79% of Safeguarding referrals and 98% of DoLS referrals were appropriate.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with knew who to raise concerns with if they had any questions relating to safeguarding. The trust safeguarding team were described as extremely visible and supportive. The safeguarding lead would identify and support safeguarding investigations from the local authority. The ward manager and matron would be involved as it related to their area and gave them ownership and offered a learning opportunity to prevent recurrence of the same or similar incidents. This is done in conjunction with the ward manager and matron, so they own it.

Staff followed safe procedures for children visiting the ward. At the time of the inspection visitors to ward areas were restricted in line with the trust's Covid-19 pandemic response plans.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. The trust had monthly infection prevention control audits, these were divisional wide and compared scores cross site and for individual wards. Dependent on the score the areas were either rated red (lowest scores), amber (some improvements required) or green (meeting targets). Based on the scores given action points were created. We observed high intensity cleaning in progress on several wards within the directorate with specialist teams identified to increase cleaning of frequent touch points.

We observed wards had also introduced "ring the bell for clinell" all staff were to pause and clean high touchpoint areas when the bell rang. The trust had introduced a standard operating procedure to ensure this was carried out consistently.

Specialist cleaning teams were also allocated to clean rooms after a patient discharge in order to allow usual ward staff to continue with the usual daily cleaning. This ensured patient flow throughout the hospital.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). During the inspection we observed staff using PPE appropriately and wearing masks throughout our visit. There was also clear signage on the wards to show Covid-19 risk levels for different areas and where patients were being isolated due to infectious diseases or illnesses. PPE provision on wards was monitored daily to ensure there were no problems with supply.

The trust also had daily bulletins which could be used to share key messages such as about Covid-19 and steps required to prevent the spread of infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff mostly responded when called. However, we observed a patient on one ward decide to mobilise without the aid of a nurse despite being asked to call for help. As she was “fed up of waiting”.

The design of the environment did not always follow national guidance. Some of the wards we visited were old and required refurbishment. The trust had plans in place regarding refurbishments and were working through the wards. Time scales were sometimes changeable according to ward risks. However, senior ward staff and matrons were aware of changes and involved in ensuring the wards they were being decanted into were suitable for the patients within their care. For example; the cardiac monitored patients would all be moved into an area that would always be able to provide the same monitoring facilities to ensure safety of the patient.

The discharge lounge was an old mental health secure unit. There was identified space in each bay for six patients. However, there were only effective curtained areas for four patients. This meant if the area did reach capacity some patients may not be afforded privacy. (Health Building Note 04-01 – Adult in-patient facilities 4.21 Privacy).

Staff carried out daily safety checks of specialist equipment. However, we observed out of date or missing items in three resuscitation trolleys. We raised this whilst we were on the wards and items were renewed and replaced immediately. This was then raised with ward teams across the division to ensure all staff were aware of the importance of checking this equipment.

The service had suitable facilities to meet the needs of patients’ families. Wards we visited had day rooms equipped with items of furniture and memorabilia designed to enhance care and support of patients living with dementia. Unfortunately, due to the Covid -19 pandemic these had not been fully utilised in recent months. However, ward staff were now starting to use these facilities again with patients and families in accordance with Covid-19 safety policies.

The service had enough suitable equipment to help them to safely care for patients. New cardiac monitoring equipment had been purchased in order to fully refit cardiac short stay after refurbishment.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including sharps. Sharps bins seen were appropriately labelled and stored correctly.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. The form was within the patient pathway document. Scores were completed correctly. When a concerning score had been calculated the patient would be escalated for medical review. All patient records we reviewed identified when escalation was required and a plan of care for the patient.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The patient pathway document included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE). Staff knew about and dealt with any specific risk issues. We were shown information on one ward that identified a 70% reduction in pressure ulcers over the year.

Staff knew about and dealt with any specific risk issues. The trust had processes in place to ensure patients received specialist care when required. If patients scored more than five on their NEWS, then they would be seen by the critical care outreach team and if they had a score of more than seven then they would receive an immediate response by the critical care outreach team. We observed this within patient care records.

Staff completed monthly VTE audits, in September 2021 the audit score was 95% for medical wards. This indicated staff were following the trusts policies correctly and reducing risk for patients.

Patients identified at risk of falls were provided with non-slip socks an identifying wristband and a flag on the patient management system. Senior nurses on all wards reported improvements in falls and pressure ulcer management. Ward information boards also displayed this information on safety crosses to highlight to patients and visitors about what was being done about patient safety.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

Staff shared key information to keep patients safe when handing over their care to others. Staff used a handover sheet to record key information when handing over care to other staff. If patient risk levels were high nursing staff from the ward would accompany the patient to move to the new ward area.

Shift changes and handovers included all necessary key information to keep patients safe. Each area had a safety huddle twice a day. All staff on duty attended the huddle and were updated on all key information. We observed a multi-disciplinary safety huddle on one of the wards which enabled staff of several disciplines to discuss safety concerns regarding a patient discharge in order that problems could be rectified in a timely way. Information was also shared on the electronic patient boards in terms of which patient referrals had been made and accepted.

Staffing

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Medical care (including older people's care)

The service had enough nursing and support staff to keep patients safe. Each ward staffing establishment was reviewed at least twice yearly in order to ensure meeting safe staffing standards. During our inspection the wards we visited were staffed in line with these guidelines. The trust had recruited a large cohort of overseas nurses in order to increase substantive staffing numbers. The trust also had a bank of nurses in order to ensure staff familiar with trust policies and procedures were employed where possible. Ward staff were also offered overtime where possible. However, to maintain these establishments most wards were still required to use bank and agency staff. The trust was working towards a reduction in agency spend with increased recruitment and talent management in order to ensure skills were used for the benefit of the local population.

Managers accurately calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants needed for each shift. Managers populated a staffing software which determined the level of acuity and dependency for patients. This calculation informed the nurse to patient ratio and skill mix as well as quantity of registrants on duty.

The ward manager could adjust staffing levels daily according to the needs of patients. Staffing was managed across the trust by daily staffing meetings and staff could be moved to help support areas with lower staffing/higher acuity.

During our inspection the number of nurses and healthcare assistants matched the planned numbers.

The service had reducing vacancy rates. At September 2021 the hospital had a vacancy rate of 15% for registered nursing staff, nurse associates and unregistered staff. Staff we spoke with identified a total of 132 vacancies (registered and non-registered staff) across both sites. However, there were 47 new starters waiting to join the trust.

The service had increasing turnover rates. At September 2021 the hospital had a turnover rate of 20% for registered nursing staff, nurse associates and unregistered staff. Staff told us that this was due to the impact of Covid-19 on staff. However, several staff we spoke with told us they were not leaving the trust but moving areas or promotions within the trust. Senior staff we spoke with identified an increase due to staff fatigue in order to recognise this they told us the trust had done extra work around resilience and supporting staff with their mental health.

The service had reducing sickness rates. At September 2021 the hospital had a sickness rate of 6% for registered nursing staff, nurse associates and unregistered staff.

For the medical wards the Allied Health Professional vacancy rate was 5%, turnover rate was 24% and sickness 5% (September 2021).

The service had reducing rates of bank and agency nurses used on the wards.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe. We observed signed documentation identifying each bank nurse's orientation to the wards.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Medical care (including older people's care)

The service had enough medical staff to keep patients safe. However, it was necessary to rely on the use of locum staff to do this. During August and September, the total number of shifts unable to be covered was 1,336. Of these 48.5% were covered by agency, 3.6% were covered by care1 bank (a collaborative regional bank arrangement with other trusts); and 45.4% were covered by internal bank.

The medical staff almost matched the planned number there were 2.4% of shifts unfilled during August/September 2021 (33/1336).

The service were working towards reducing rates of bank and locum staff. The Trust's internal controls in managing gaps was to go through internal bank arrangements to cover gaps first, and then if unable to find cover, to go out to agency. This was supported and controlled by a central team. As part of the central teams' controls, core shifts within medicine were not left unfilled, only those shifts deemed to be low risk to patient safety would be left unfilled. If a core shift was unable to be covered through the bank, or agency, alternative mitigations were applied to ensure the shift was covered including the use of acting down arrangements.

The service had reducing vacancy rates for medical staff. Pilgrim Hospital had a vacancy rate of 22% for medical staff across the wards in September 2021. This showed a slight decrease on the August vacancy rate of 24%.

The service had low and/or reducing turnover rates for medical staff. Pilgrim Hospital had a turnover rate of 0% for medical staff across the wards in September 2021.

Sickness rates for medical staff were low and/or reducing. Pilgrim Hospital had a sickness rate of 1% for medical staff across the wards in September 2021.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. A locum member of medical staff who we spoke with told us they had an induction and a tour of the department when they started in post.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Staffing was a key area of focus with a range of reviews and controls in place.

The service always had a consultant on call during evenings and weekends. During the pandemic some wards had also utilised virtual consultant ward rounds to ensure effective patient care decisions were made.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Notes we looked at were easy to follow and consistently completed. The trust had standard booklets and forms to fill out for patients notes which helped staff to ensure comprehensive records were kept. The matrons completed records audits and monitored standards throughout the ward areas to ensure consistency.

When patients transferred to a new team, there were no delays in staff accessing their records. The trust had an electronic system on which staff recorded observations, key information and treatment plans. This was accessible on all wards and enabled staff to quickly identify areas of risk and treatment plans for patients on the ward.

Records were stored securely. On the wards we visited notes were stored in lockable trolleys which were locked when not in use by staff. On all the wards we visited these had been moved so they now were stored in the patient bays to ensure staff members were more visible when completing their notes. There was also space for staff to sit in the bays to maintain observation of patients when required.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Charts demonstrated medicines were prescribed and recorded appropriately. Medicines were stored in patient lockers and there was a process to ensure these were replenished as needed. Where medicines had not been recorded as administered, we saw this was identified and we were told that critical medicines that were omitted without reason would be reported through the trust's electronic reporting system. This was also audited and actioned as part of the matron reviews.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Ward and medical staff spoke to patients about their medicines, occasionally a pharmacist would also speak to patients e.g. regarding use of inhalers.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We did not identify any concerns with the storage of medicines. Staff on one ward were not aware of the use of the trust paperwork to support risk assessing self-administration of medicines, staff on other wards were using this documentation to support patients in managing their medicines.

Staff followed current national practice to check patients had the correct medicines. We saw evidence of timely medicines reconciliation. (within 24-48hrs of admission). When patients were admitted over a weekend their charts were prioritised for reconciliation when pharmacy team members arrived on the ward on Monday. We heard that, due to time constraints, not all charts were reviewed by pharmacy staff daily, but patients were prioritised for review based on complexity of treatment regime, discharge and admission dates.

The service had systems in place to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff advised that where necessary the pharmacy team handled medicines alerts.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw no evidence of peoples' behaviour being controlled by excessive or inappropriate use of medicines. During the inspection we spoke with staff who were aware of the sedation policy and any previous incidents. All wards now had sedation logs and staff were aware of where these were stored.

The trust had taken part in the Medicines Optimisation in Care Homes programme. This was a project commissioned by Health Education England (HEE), on behalf of NHS England (NHSE), to provide education for pharmacists and pharmacy technicians in order to reduce the amount of unnecessary medicines patients in care homes were receiving.

The team achieved two out of the three specific standards and were able to medically optimise patient medication that previously would have gone unchanged. Potentially leading to poor patient outcomes and increased readmission rates.

Medical care (including older people's care)

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Staff said they were encouraged to report incidents and near misses.

Staff on the respiratory ward were able to explain the actions taken from the December 2020, 'Deterioration due to rapid offload of pleural effusion fluid from chest drains' national patient safety alert. The ward now had a specific dedicated area for ultrasound guided pleural drainage to improve observation and constant monitoring of patients undergoing this procedure.

The service had no never events on any wards. Managers shared learning with their staff about never events that happened elsewhere. There were quarterly trust wide learning to improve bulletins that were circulated to staff. These covered learning actions taken from serious incident investigations across the trust.

Staff reported serious incidents clearly and in line with trust policy. We reviewed the last three serious incident reports for the medicine wards at Pilgrim. These were clearly written, thoroughly investigated and identified areas of good practice and areas for improvement. Staff we spoke with were aware of serious incidents within their own division and across the two sites.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence that changes had been made as a result of feedback. The trust had previously identified a number of serious incidents in relation to Diabetic ketoacidosis (DKA). This resulted in the diabetes ward not taking any new admissions with DKA and instead they would be cared for on the Acute Medical Short Stay (AMSS). The ward then did work to train staff and recruit additional nurses and had plans to restart taking those patients once the work had been completed. As a result of learning from incidents the respiratory wards staff were creating a pilot discharge checklist for patients going home on domiciliary non-invasive ventilation to ensure all elements of care and training were covered on discharge, thereby reducing readmission.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The deputy director of safeguarding was also part of the serious incident panel in order to identify any safeguarding concerns which may need further investigation or expert opinion.

Managers debriefed and supported staff after any serious incident. Staff we spoke with said that several of the team had undertaken human factors training. The importance of debriefing was highlighted to all staff particularly with aggressive patients or difficult situations. Debriefs were done with staff at the time of an incident where possible and then teams were offered formal training and/ or support.

Medical care (including older people's care)

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The NHS Safety Thermometer provided a 'temperature check' on harm that could be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for all patients. Following consultation, the national collection of data stopped in April 2020 with the proposed development of replacement data collection and reporting then impacted by the COVID-19 pandemic.

Staff used the safety data to further improve services. Leaders reviewed their team's performance regarding the trust quality assurance dashboard and areas for improvement were cascaded throughout staff teams. Operational performance data was collated and reviewed at the trust's divisional board meetings.

Is the service effective?

Good ↑

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff said guidance was easy to access, comprehensive and clear to follow. They showed us how they accessed the guidance.

We saw clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

There was a trust wide improving respiratory services programme which had started at the time of the inspection. The trust had recently completed a new respiratory unit at Lincoln Hospital and had plans to develop the service on the Pilgrim site. This met current best practice guidelines and standards and allowed staff to safely care for patients.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff working with people who were detained had support from the safeguarding team to ensure patients' rights were protected. Patients also had access to advocates who were independent from the trust who they could speak to raise concerns or queries.

At handover meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. During the inspection we observed staff offering a choice of meals for their lunch with different options available. During the inspection we spoke with patients who told us that they had plenty of choice and that the food was good.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We observed these charts completed and reviewed accordingly in all the records we reviewed.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed. Nutrition and fluid care plans were followed with fluid balances totalled and acted upon appropriately.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain scores were recorded in most patient notes. Staff used pictorial aids to assess the pain of patients who could not communicate verbally.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Staff working in the trust described how the pain team used to be based in the hospital three days a week and were now based in the community. They described them as being less visible but still able to make a referral to them and have patients assessed when required. This service was mostly identified for patients suffering chronic pain. Acute pain was managed within the hospital by medical staff or anaesthetists.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Audits included the National Lung Cancer Audit, National Audit of Dementia, National Audit of Inpatient Falls, and National Diabetes Inpatient Audit. The service did submit some data to the Sentinel Stroke National Audit Programme but the main site for acute stroke care was at the Lincoln County Hospital so the data for Boston Pilgrim hospital was not comparable to other acute stroke units. The Trust was participating in 97% of all relevant national clinical audits and was in the process of registering for the inflammatory bowel disease audit which would make them 100% compliant.

Outcomes for patients were varied and did not always meet expectations, such as national standards. The National Lung Cancer Audit 2020 (based on 2018 data). This showed that the service performed worse than expected for all metrics. This information had identified problems with data collection, which the trust had produced an action plan to address.

However, the National audit for Dementia 2019 identified Pilgrim Hospital was in the top 75% for three out of four metrics. We were able to observe improvements in the fourth metric as all case notes we reviewed demonstrated multi-disciplinary team involvement in discussion of discharge.

The Myocardial Ischaemia National Audit Project (MINAP) Summary Report April to June 2021 data identified 97 % of patients received Primary Percutaneous Coronary Intervention (PPCI also known as angioplasty or coronary angioplasty, is a procedure used to treat the narrowed coronary arteries of the heart and angina in patients), from arrival to treatment within 90 minutes of admission. Quarterly national data was not available however, this data identified improved patient outcomes for the local population of Lincolnshire.

Managers and staff used the results to improve patients' outcomes. The trust were committed to being involved in 100% of audits in order to ensure improvements for patients. Information from audit was fed back to ward staff and learning embedded by use of a folder with recent SI's and learning and any changes of practice. Information was also cascaded through the huddles. Governance meeting minutes also provide information for ward staff. For example, an audit identified ECG results were not escalated in a timely manner this led to changes in order to improve review of these results.

From April 2020 to March 2021, patients at the Pilgrim Hospital had a higher than expected risk of readmission for elective admissions. However, this data could not be compared to other years as a result of the Covid pandemic.

The service had a lower than expected risk of readmission for non-elective care than the England average.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time with a specific quality governance results and action plan form. We reviewed three such audits which were clear and comprehensive noting areas of improvement and meeting with national guidance and where appropriate identifying further scope for learning. Further audits were more ward based and targeted for example the trust carried out monthly sepsis audits on all the wards. These identified if there were any delays in treatment and possible reasons for this. Most wards had improved results from August to September 2021.

Outcome data was reviewed at specialty and divisional quality and safety meetings. These included learning from deaths. The reports seen included details of all national and local audits. Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored. We saw that action plans were in place to support improvements. For example, an action plan detailed five action points to address the results of the National lung cancer audit these were either completed or on track during our inspection.

The trust had its own internal accreditation scheme. This scheme had a clear process in place for monitoring quality in all clinical areas. Wards were RAG rated each month following completion of an audit undertaken by a matron. Once a ward had achieved the desired rating of green for consecutive months, accreditation status would be given.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Across the medical wards a number of overseas nurses had recently been recruited. They had a bespoke support package in place to ensure they were fully supported both in work and outside of work to help them to settle into their roles and encourage them to stay. They had competencies that they had to complete before they were signed off to complete certain tasks such as intravenous (IV) medication and were also supernumerary until they were assessed as competent and felt personally competent to care for patients independently.

Managers supported staff to develop through yearly, constructive appraisals of their work. Across the medical division there was an average appraisal completion rate of 60%. The trust had a plan and targets they wanted to achieve to increase appraisal rates after they were paused due to the pandemic. A new job management software package had recently (May 2021) been introduced to support and improve the quality of appraisals, including clear objective setting, career and development conversations, wellbeing conversations, and aligning performance and behaviour to the trust values. The system was still very new to the trust and had not been fully embedded. However, we observed an action plan which contained six actions the division were working towards, documented at the August 2021 'medicine performance management framework meeting'.

Junior doctors received weekly teaching and said there were no issues attending this. They described a good level of teaching from consultant staff. Senior medical staff told us that new junior doctors received teaching sessions when they started in a new department and that regular half day teaching sessions were included in their working rotas as protected time.

Therapy staff were supported by therapy support workers who worked across different therapy disciplines. Support workers completed competencies in order to develop specific skills.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that they had completed extra training specific for their roles and that this was easy to access and helped them to develop.

Managers made sure staff received any specialist training for their role. Specialist teams provided regular bite size training to ward staff to maintain their specialist skills.

The clinical educators supported the learning and development needs of staff. There were specialist nurses who had a remit to support staff in developing specialist knowledge and skills. This was through advice and support, training sessions and the signing off of specialist competencies. There were specialist nurses for example in respiratory, oncology and frailty.

Managers identified poor staff performance promptly and supported staff to improve. This could be done through informal support on the ward or through formal processes dependent on the concerns identified.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Throughout the inspection we saw multidisciplinary team (MDT) working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team.

Medical care (including older people's care)

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, the oncology MDT specialist nurse, radiologist, consultant surgeon and oncologist were routinely meeting together to make decisions regarding recommended treatment of individual patients. In addition, we observed that there were daily multidisciplinary board rounds held on each ward. These were attended by nursing, medical and therapy staff with a purpose of sharing up to date information about patients and making shared decisions about their care and treatment plans and discharge planning. We observed that all staff had a voice during these meetings and there was effective discussion as an MDT. Therapy staff explained that although there was pressure to discharge medically fit patients, medical staff respected therapists' opinions when they felt patients were not ready for discharge.

We observed nurse consultants working cohesively with medical colleagues to provide care and treatment across the department.

Staff worked across health care disciplines and with other agencies when required to care for patients. There were good working relationships between nursing and therapy staff, and we saw that there was a holistic approach to patient care. Therapy staff worked with nursing staff to incorporate rehabilitation into routine ward activities to ensure therapy was purposeful. As the Stroke service had relocated to Lincoln during the pandemic mobile teams of OT/physios and support staff visited all stroke patients on other wards to provide specialist rehabilitation and updating care plans for ward staff to continue targeted therapy.

There was a recognition that therapy resources were limited and that nurses could incorporate a rehabilitative approach into their care based on advice from therapists. Therapy staff worked with community rehabilitation services to coordinate safe discharge and continuation of care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The mental health liaison team was available for advice and to support ward staff care for patients with mental health needs. During both days of the inspection we saw the mental health team working and assessing patients on the wards we visited.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. During the pandemic in some area's wards had completed virtual ward rounds if patient acuity allowed. This had been particularly successful within cancer services. The cardiac wards had daily ward rounds with a consultant or on Tuesdays and Thursdays with another senior member of the MDT. This ensured patients with a plan of care were consistently reviewed and allowed for the consultant to review and plan care for new patients in the emergency department or on other wards.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff described how it could sometimes be difficult to get specialities to review patients at weekends.

Health promotion

Medical care (including older people's care)

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support available on wards. Information leaflets were available on request throughout the service for patients and relatives to promote a healthy lifestyle.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff could refer patients to external organisations for specific support needs such as stopping smoking or drinking alcohol. Staff we spoke with told us there was 24-hour response from the alcohol liaison team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff completed mental capacity assessments in patient records where there were concerns over an individual's ability to consent to care and treatment. Staff were able to explain the process for assessing a patient's mental capacity. The process was clearly documented in patient's records. For example, we reviewed the records of 10 patients who were under a DoLS application and we saw that in each case a mental capacity assessment and best interests' decisions had been completed. All MDT meetings for best interest decisions, were recorded and minuted, these remain with the patient medical notes to ensure should they be required for any legal proceedings everything is together and fully documented.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. During the inspection we observed staff asking for verbal consent before undertaking any care and treatment.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were completed correctly.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act training was mandatory and 71% had completed this training.

Managers monitored the use of Deprivation of Liberty Safeguards and Mental Capacity Act and made sure staff knew how to complete them. Monthly audits were completed which identified good practice and wards where improvement was required. These were discussed at a safeguarding oversight meeting and support plans agreed for wards requiring targeted training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and

guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were supported in making decisions in line with legislation and guidance by the safeguarding lead. The lead had a visible presence on the medical care wards from Monday to Friday to offer specialist support and advice to staff. Staff told us that if they required advice, they could easily access the safeguarding lead.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw from the patient records we reviewed that all DoLS applications had been made in line with trust process. All staff had completed mental capacity assessments around the specific question of being able to give consent to remain in care and to care arrangements. Urgent and standard DoLS applications were made on appropriate paperwork and the dates were accurately documented.

The trust are in the process of producing an MCA checklist for complex discharges. This will support nurses and discharge coordinators to ensure they have considered any specific concerns that may be related to the individual care of a patient living with a condition that affects their mental capacity.

Is the service caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff told us how they spent time getting to know the patient as an individual to ensure that they were aware of their wishes and how best to support them.

Patients said staff treated them well and with kindness. Patients we spoke with told us that staff were all very kind and caring “spot on above excellent care”.

Staff followed policy to keep patient care and treatment confidential. During the inspection we saw curtains being used to protect the privacy of patients when delivering any care, treatment or discussions.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Medical care (including older people's care)

Staff gave patients and those close to them help, emotional support and advice when they needed it. All staff we spoke with clearly understood patient needs.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us there was e-learning on End of Life Care, and the Human Factors Training that covered these conversations. Teams were also encouraged to contact the chaplain for support.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff explained how they would include patients loved ones in discussions about their care if this was the wish of the patient.

The hospital had a cancer care coordinator whose role was to assess and support the holistic needs of the patient.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with generally reported that they felt involved in their care and decisions and that staff were approachable and felt able to ask any questions they had.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Some patients reported they benefited from the nurse in charge returning to them after the doctors had been to go over information and ensure full understanding.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. On all the wards we visited there was information on how patients and their families could give feedback on their care. Staff were proactive in seeking patient and relatives' views in order to improve care.

During the inspection we were told about how patients could feed into improvements they would like to be made on the wards and on one ward how they could add items onto a 'wish list' to be paid for by charitable money.

The trust used patient stories to share where care and treatment had met the expectations of patients and where there were improvements to be made.

For August across the medical division 83% of patients surveyed would recommend the trust as a place to receive care.

Staff supported patients to make advanced decisions about their care. The trust had an end-of-life team who specialised in palliative and end of life care. This team supported both patients and staff to make advanced decisions about care.

Staff supported patients to make informed decisions about their care. Staff had access to specialist teams who supported patients. For example, cancer, diabetes, stroke and mental health specialist teams visited the wards regularly.

Patients gave positive feedback about the service.

Medical care (including older people's care)

Is the service responsive?

Good ↑

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the changing needs of the local population. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were all aware of the dementia liaison team and their contact details and reported a good collaboration with them.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were mostly appropriate for the services being delivered. Waiting areas, clinical rooms and bays contained the required equipment according to internal policies and national regulations.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospital had a frailty team who worked closely with the emergency department these patients were fully assessed with the aim to have them discharged on the same day.

There was an enhanced patient supervision policy which identified the process for identifying patients requiring additional supervision and ensuring appropriate enhanced supervision requirements were met. There were patient boards above beds which used symbols to identify if patients had special care requirements. These symbols were also used on the patient status at a glance board which was located at the ward nursing station. Symbols were used to identify if patients had dementia, were at risk of falls or required support from specialist nurses or therapy staff.

The oncology and haematology service included a specialist team of staff able to provide care treatment and holistic discharge planning. Patients could also directly return for acute reassessment as necessary to reduce emergency admissions through the emergency department.

The service relieved pressure on other departments when they could treat patients in a day. The medical care service worked closely with urgent and emergency care, the care coordination centre and the same day emergency care (SDEC) service. There was a clear inclusion criterion that patients must meet in order to be eligible for care there.

There were identified short stay wards and an acute medical unit which supported patient flow. There were regular site meetings involving medical care staff to review and discuss any blockages in the emergency department and how medical care could support these. Medical care reported its bed status at a daily bed management meeting which meant the hospital had oversight of bed capacity. Daily multidisciplinary board round meetings enabled staff to make timely decisions about patient discharge to ensure patients did not have any unnecessary length of stay days.

Medical care (including older people's care)

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff linked in with leads across the trust for support and guidance. They also worked closely with patient's usual care delivery teams to ensure their needs were met. The trust also had homeless support officers in the hospital.

Wards were mostly designed to meet the needs of patients living with dementia. A number of the wards had recently undergone refurbishments and had improved their accessibility for people living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff had re-introduced the 'Hello, My Name Is' campaign, with the use of placemats with ward information and ward leader and matron names were in place on 7B and were to be implemented on all gastroenterology and respiratory wards. Also wards in specialty medicine had signed up to a telephone project pilot to improve communication with patients' families.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The referral system was through the online electronic record used throughout the hospital, so it was quick and easy to refer patients for speciality referrals and beds.

The Acute Medical Short Stay (AMSS) flow coordinator and discharge team checked all patients at the start of each shift and identified which patients were suitable to use the discharge lounge. They also used the patient board to identify what individual patients were waiting for.

The trust used the discharge lounge for a place for patients to be cared for instead of waiting in the emergency department while they were awaiting an assertive in-reach assessment (AIR - frailty assessment). Patients were reviewed against specific criteria to ensure their suitability including risk assessments and suitability for same day discharge. However, on occasion this resulted in patients, at times, being in the discharge lounge for long periods of time. In August

2021 there were 16 patients who were in the discharge lounge over 12 hours and September 18 patients. These instances were when decisions needed to be made to transfer medically optimised patients for discharge the next day or from the emergency department for an AIR review. The patients were moved to the discharge lounge overnight then were seen by the team in the morning before usually being discharged out that afternoon.

Managers and staff worked to make sure patients did not stay longer than they needed to. On the oncology/ haematology unit there was a part time discharge coordinator three days a week. At the time of our inspection an audit was in place to identify the need for this service to increase to five days a week. Staff on the ward told us that on the days that the discharge coordinator was not available flow on the ward was affected. The complex requirements of the patients also required consistent discharge planning from staff that understood any ongoing difficulties they may encounter.

The service moved patients only when there was a clear medical reason or in their best interest. There were 1016 patients moved from one medical ward to another in September 2021.

Managers and staff worked to make sure that they started discharge planning as early as possible. The average length of stay across all medical specialties was longer than expected for both elective specialties at Boston Pilgrim Hospital. Average length of stay across all the wards was 5.1 days with the longest average length of stay on the health care of the older person wards (11 days each). The average length of stay for the AMSS was 5.1 days. Patients on all wards were identified as medically fit for discharge when possible. However, access to community care was extremely limited. This meant that on occasion patients became unwell again before they could be discharged. The trust was working with community partners to increase services however this remained a challenge.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff working on the wards aimed to plan discharge when patients were admitted ensuring the process was as short as possible. However, a discharge checklist audit was to commence as patients have been discharged without all checks completed and this had contributed to complaints to PALS. Findings were to be shared with the documentation group to discuss the appropriateness of the current checklist with a view to making it more user friendly in the future.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The trust worked with the local system to make them aware of delays relating to discharge and to facilitate discharges. There were some medical wards with high numbers of medically fit patients. Staff used 'Right to Reside' information to identify where people could be discharged to. 'Right to reside' means you have the right to live in the UK. The trust had implemented 'Right to Reside' and the sharing of information with system partners. System partners joined the 6pm daily flow meeting to discuss bed availability in the community.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Occupancy across the wards was 99%.

Managers worked to minimise the number of medical patients on non-medical wards. Where medical patients were not on the speciality wards they required, there were clear processes for a medical review to continue to ensure their care and treatment was not impacted upon.

Learning from complaints and concerns

Medical care (including older people's care)

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Across the medical wards there were 122 complaints received in the last year. The most common themes were communication, delay in treatment or diagnosis and being discharged too soon.

The service clearly displayed information about how to raise a concern in patient areas. We saw posters detailing the complaints process on all wards we visited. There were patient feedback leaflets on all the wards. The trust responded to complaints within set timescales and followed their internal policies as well as the national guidance. Staff told us how the duty of candour was met, including recording of the process and the involvement of patients and families.

Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process, and give examples of when a complaint was received, how it was handled and the outcome.

Managers investigated complaints and identified themes. The average time taken to respond to complaints was 59 days.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed two patient complaints in relation to medicine at Boston Pilgrim Hospital, the response addressed all points raised by the complainants, gave detailed responses and were written in a sympathetic manner.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Serious incidents which were at the origin of complaints were discussed with staff and escalated.

Staff could give examples of how they used patient feedback to improve daily practice. Following an increase in complaints on respiratory wards whilst visitors were not allowed on site, a contact list for patients next of kin was now in place to provide updates.

Is the service well-led?

Good ↑

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Medicine had its own division within the trust's management structure. This division included all the medical wards and the urgent and emergency department. The leaders worked in a multi-professional triumvirate which included a manager, doctor and nurse. Care group senior managers and clinical leads were seen regularly in ward areas. Staff felt able to raise concerns and were confident their concerns would be listened to and acted upon. Ward staff said they were well supported by their ward managers and matrons.

Medical care (including older people's care)

We observed good leadership skills in all ward areas. Leaders were seen giving clear directions and support to junior colleagues.

Staff were encouraged and supported to develop their skills and take on more senior roles. There were development pathways to support staff to progress.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had five key values:

- **Patient-centered-** Putting patients at the heart of our care.
- **Safety-** Ensuring patients and staff are free from harm.
- **Excellence-** Supporting innovation, improvement and learning.
- **Compassion-** Caring for patients and loved ones.
- **Respect-** Treating our patients and each other positively.

During the inspection we observed staff to be displaying these behaviours in the care and treatment they delivered.

The trusts vision was to be outstanding and was led by the trusts board. The division's vision mirrored that of the trust. Individual wards also developed their own visions which was specific for the patients they treated and the staff they had on the ward. For example; ward 6B provided a board vision to identify 'Together Everyone Achieves More' highlighting that they were a cohesive team working hard to provide safe care to all their patients. The Bostonian ward support each other with a 'What Matters to Me' board and what mattered to them was that they provided "outstanding personalised care". A number of areas also had boards identifying small ways they could improve care by "looking after their own wellbeing" and "grabbing every opportunity to learn new things".

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt valued, supported and spoke highly of their jobs. Staff said there was good teamwork and peer support. Staff spoke enthusiastically about their jobs. Most staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients.

Staff were proud to work for the hospital; they were enthusiastic about the care and services they provided for patients. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work.

Medical care (including older people's care)

On the wards we saw multidisciplinary working which involved patients, relatives, and the clinical team working together to achieve good outcomes for patients.

Patients acknowledged a positive and caring ethos and were happy with their care.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear governance structures within the trust with good representation from all disciplines. Governance group meetings directly fed into the trust board governance meetings.

There was a clear governance structure within the medicine group. Monthly meetings took place at all levels to discuss key risk and performance issues. Meeting minutes showed them to run to a set agenda and clearly recorded.

The medicine division also had monthly dashboards which covered data from across the wards and was collated into an overall performance report for the division. This highlighted areas of good practice and areas where improvements could be made.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Risks were recorded at ward division and trust level. The top three risks identified were the safe management of emergency demand, timely provision of Non-Invasive Ventilation (NIV) and capacity to manage emergency demand. These all had control measures in place, identified weaknesses/gaps in controls, planned actions and recorded progress. Leaders at all levels could clearly describe the risks in their area of work and the mitigation in place to reduce the risks. Monitoring of risks and actions were allocated to named staff who recorded regular updates with the mitigations to reduce the risk.

Throughout the medicine division, clinical and non-clinical managers worked well together to identify risks and make improvements. Matrons and ward managers had a good understanding of the issues within their clinical areas.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Staff were aware of how to use and store confidential information.

Each area we visited had several computer terminals and computers on wheels to allow staff to access electronic patient records and test results. All staff had individual log on passwords and all terminals were locked when not in use.

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust used the friends and family test to gather the views of people using the service. They also gathered the views of patients and their loved ones through complaint and compliments. All of this information was gathered into a monthly report which detailed any actions and learning.

The trust also held patient panel workshops where members of the public were invited to discuss a variety of topics such as changes to services. These were a useful way for project leaders to be able to gather the views of people who would be using the services they were developing.

Where a service had been reviewed or developed, a full equality impact assessment was completed. The service also had a system community database which allowed staff to engage with different groups to gather diverse views on services.

In 2019 United Lincolnshire Hospitals NHS Trust (ULHT) had become the first NHS trust in the country to be formally accredited by the 'Academy of FAB NHS Stuff'. The trust now had FAB Experience Champions identified on medical wards who acted as local leads for patient experience. Some of this work was new but aimed to engage with patients, families and their carers to improve care. For example, new monthly FAB Champions feedback on activities and patient panel discussions covered all aspects of care. This information all fed into the Medicine Division Patient Experience assurance report which provided an overview of themes and actions.

Each month a newsletter was produced to identify to all staff any patient feedback that had been received and any common themes. This information was also discussed at a monthly patient experience meeting.

All wards we visited also had poster boards to identify to patients and relatives 'you said we did'. For example, on The Bostonian ward patients identified they would benefit from radios, activity packs and extra snacks. So, the ward used some donated money to buy radios, sourced activity packs for all patients and now provide a 'snack train' daily for additional nutrition.

Daily bay inspections by the ward sister/charge nurse were having a positive effect on patient feedback as patients were happy to be cared for in a clean and tidy environment. There were also plans to reinstate ward lead ward rounds with a focus on communication.

Learning, continuous improvement and innovation

Medical care (including older people's care)

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Following the last inspection, the trust had taken action to address the issues found across the service.

The trust had monthly medicine division confirm or challenge reports. These explored different measures across the trust and dependent on risk level identified drivers for change or metrics to continue to monitor. Each month these were updated dependent on risk levels and actions completed to improve the services across the trust. Areas for improvement including reducing medication errors causing moderate or severe harm and reducing agency spend for the year compared with the previous year.

The trust took part in a 100 day challenge with the community service to allow a smoother and more rapid (where appropriate) transition from hospital to home/community for individuals who had suffered a stroke and to allow people to be managed and to manage confidently in the community. As a result of this the team awarded a Chief Allied Health Professional Office (CAHPO) Award in October 2021 for Innovation and Delivery of Systems in relation to the 100-day challenge and all the progress they had made this year. This was one of 7 awards given out in England.

Services for children and young people

Good ↑↑

Is the service safe?

Good ↑↑

Mandatory training

The service provided mandatory training in key skills to all staff. However, challenges to accessing training as a result of the Covid-19 pandemic meant not all staff were up to date.

Nursing staff received and kept up-to-date with their mandatory training. Training was a combination of face to face training and online learning and included sepsis training and infection prevention and control. Although time to complete training was not scheduled into the rota, ward managers ensured that staff used quieter periods to complete training and the clinical educator alerted staff when they were approaching completion deadlines.

We reviewed a snapshot of compliance data on 18 October 2021 and found nursing staff on the neonatal unit and outpatients' department achieved 100% compliance for almost all of the modules which met their target of 90%. Exceptions to this were for fraud awareness which was 67% and 73% for the annual resuscitation module. The children's ward had met the 90% target in most modules and between 68% and 73% for basic life support modules.

Medical staff did not manage to keep up-to-date with their mandatory training. Medical staff had achieved between 45% and 78% compliance for mandatory updates. Medical staff said they were usually given time to complete the training but that the Covid-19 pandemic had made this more challenging than usual. Managers said that medical staff were 100% compliant with all staff having completed a level of life support training. They provided data which showed 20% of medical staff had completed life support training at European Paediatric Life support (EPLS) level and 80% had achieved Advanced Paediatric Life Support (APLS) level against a target of 100%. Managers told us that APLS courses were undertaken externally and there had been difficulty in booking APLS courses due to the Covid-19 pandemic. They had booked remaining staff for the next available course which was January 2022.

The mandatory training was comprehensive and met the needs of children, young people and staff. It included life support training which was specific to children and neonates. Band four staff (staff who were experienced in working with children but were not registered nurses such as nursery nurses and nurse associates) were trained in paediatric immediate life support (PILS).

Data provided by the trust showed that 61% of nursing staff had completed European Paediatric Life support (EPLS) training against a target of 100%. Managers told us this enabled at least one EPLS trained person on each shift. All nurses in charge had completed EPLS training. Managers were aware that the Royal College of Nursing (RCN) safe staffing guidelines states a Paediatric Assessment Unit should have Advanced Paediatric Life Support (APLS) trained staff. The trust had acquired funding for this but due to the Covid-19 pandemic, there had been no external courses available. The staff were on a waiting list to attend the course and were ensuring all nursing staff completed EPLS training in the meantime as this was internally available.

Services for children and young people

Staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. This was a new programme being delivered to all staff which was due to be completed in 2022. Some staff on each ward and department had completed training to become learning disability and autism champions and were able to support other staff. This was an improvement since our last inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was reported to matrons by the ward managers via their monthly dashboards, and this was escalated upwards to the trust board.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. All nursing staff were trained to level three. We reviewed a snapshot of compliance data on 18 October 2021 and found nursing staff had achieved 100% compliance for safeguarding training. This exceeded their target compliance of 90%.

We observed staff acting as a chaperone for patients in outpatients.

Staff received training on preventing child abductions. This did not include scenario training at the time of our inspection.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff were knowledgeable about the provider's safeguarding policy and described trust wide safeguarding staff they could approach for guidance and advice. Staff knew where to access information about making a referral and who to contact on their ward if they had a concern. Non-qualified staff would inform the nurse in charge or the ward manager of any concerns but also knew how to access information about safeguarding, including the safeguarding policy and referral pathway. Staff knew there was a safeguarding lead who they could contact for advice or to escalate a concern.

Staff could access a division wide safeguarding supervision meeting via videoconference. This was run by the divisional safeguarding leads.

Medical staff received training specific for their role on how to recognise and report abuse. We reviewed a snapshot of compliance data on 18 October 2021 and found medical staff had achieved between 59% and 67% compliance for safeguarding modules which did not meet the trust's target of 90%. However, medical staff said they understood how to identify a safeguarding concern and how to act on it.

Staff knew the procedures if a child and their parent or carer did not attend an outpatient appointment.

Medical staff regularly held case reviews and safeguarding meetings with ward staff and other relevant agencies to discuss individual children's needs.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Matrons, ward managers and sisters reported a very good relationship with the trust's safeguarding team who provided advice and support to staff when needed. They had recently developed six safeguarding champion roles

to help support staff. Staff on the neonatal unit worked closely with the maternity unit and community team to plan for babies and mothers with known safeguarding concerns for the benefit of both baby and mother. Staff on the children's ward worked closely with community staff and other agencies when planning an admission for a child with a known safeguarding concern to ensure ongoing safety of the child during their admission.

Staff were informed of any known safeguarding concerns for individual children during the morning and afternoon handovers and discussed at ward rounds. The safeguarding team worked closely with the midwifery team and developed a template which identifies any issues quickly. The family and baby team (FAB) worked closely with the midwifery team and safeguarding teams and the neonatal unit to support families with a variety of issues.

Staff followed safe procedures for children visiting the ward. Siblings were allowed to visit but was restricted during the Covid-19 pandemic. Parents were asked to ensure visiting children remained with them at all times. Siblings were allowed in the play areas and sensory room with parental supervision.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were very clean and had furnishings which were suitable for children and were clean and well-maintained.

Cleaning materials were kept in a locked cupboard and a cleaning schedule was maintained by the housekeeping team. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned bed spaces promptly when there were vacated. Hazardous cleaning products were locked away.

All areas we visited had disposable curtains which were dated to show when they were last changed. All staff we spoke with were aware of when to change curtains more frequently.

There was a sensory room on the ward which was also kept clean and well maintained. There was a family room on the children's ward which was usually available to parents who were staying with their child and where siblings could play. This had been re-purposed during the Covid-19 pandemic to accommodate medical staff on the ward.

The neonatal unit had two parent's suites as part of their transitioning service. This enabled parents to stay overnight to become used to caring for their newborn after spending time in the neonatal unit. The suite included a double bed and bedroom furniture which was washable, a cot, kitchenette, bathroom and lounge area with TV. There was also space for siblings to visit.

The service generally performed well for cleanliness. Managers conducted regular audits to check compliance with infection prevention and control (IPC) policies. A recent cleaning audit on the ward showed 82% compliance and 98% for hand hygiene. We observed that staff washed their hands and used hand gel regularly and before and after every contact and completion of any task.

Staff followed infection control principles including the use of personal protective equipment (PPE). Ward managers ensured that PPE was always fully available. There was a good supply and no supply issues during the pandemic. Staff and visitors complied with the trust's infection, prevention and control (IPC) processes, including additional Covid-19 precautions which were in effect across the service. Face masks and alcohol hand gel were freely available on each ward. Staff complied with social distancing precautions when required. Information for staff and visitors regarding IPC and

COVID-19 precautions was displayed across the service, including at entrances to wards. Personal protective equipment (PPE) such as gloves and disposable aprons were used in accordance with the trust's infection control policy. Staff used alcohol hand gel when entering and exiting the wards and theatres. Handwashing facilities were appropriate and accessible. All staff adhered to being bare below the elbow.

Patients with infections or at risk of harm from infections were clearly identified and supported in side-rooms. Assessments indicated the level of infection risks associated with each patient and there was clear guidance about how to prevent the spread of infection and what PPE was to be used.

When possible, patients were tested for covid prior to admission and there were procedures in place to test unplanned admissions upon arrival. Patients requiring planned surgery were tested three days before admission to the ward. There was a dedicated Covid-19 information board for staff, patients and visitors explaining how to identify symptoms and prevent its spread. There was a dedicated infection, prevention and control lead to educate staff and visitors and promote good infection control practices.

Staff cleaned equipment after patient contact and labelled equipment with 'I am clean' stickers to show when it was last cleaned. All 17 pieces of equipment we checked were clean and labelled.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Children, young people and their families could reach call bells and staff responded quickly when called. Patients who were unable or unlikely to use call bells, such as very young patients were kept under close observation of the nursing staff.

The design of the environment followed national guidance. The service had arrangements in place to ensure children and young people wards and clinics were secure. The main entrance to the neonatal unit and ward could only be opened by a dedicated key card. Staff also had to electronically open doors for anyone without a swipe card to leave the ward. We saw staff use an intercom to check the identity and validity of people requesting access to wards. Fire doors were alarmed so patients were unable to leave without staff being alerted. Non patient rooms and areas within the ward had dedicated key code locks to prevent unauthorised access to items which could be harmful or confidential.

The layout of the neonatal unit was such that all cots and incubators could be observed constantly. Two of the cots were designated as high dependency cots and all cots had enough space around them for staff to care for babies and for parents to sit in an armchair beside their baby. There was a separate isolation room for when this was required. All equipment was easily accessible, and all cots could be seen from the ward manager's office.

Parents had access to a shared kitchen and lounge area where they could make a hot drink and a snack. There was also bathroom and shower facilities for parents and individual lockers so that they didn't need to take all their belongings into the nursery and to avoid clutter.

There was a milk kitchen and preparation area on the neonatal unit and the ward for the safe preparation of milk feeds. There was a fridge specifically for storage of breast milk, which was kept locked.

Parents had access to breast pump equipment and access to a private room to express their milk. There was a breastfeeding resource box for mothers which provided information and clear guides, including the UNICEF national guidance. Sterilising equipment for feeding bottles was provided for individual babies and labelled with the child's name. All of the three pieces of disposable feeding equipment we checked were in date. Food products were available for babies and children and all four items we checked were in date.

Staff carried out safety checks of specialist equipment. Maintenance staff completed regular safety checks of electrical equipment. Out of 17 pieces of equipment we looked at, all apart from one had a sticker to show when it was last tested and were in date.

The service had suitable facilities to meet the needs of children and young people's families and enough suitable equipment to help them to safely care for children and young people. Cots, incubators and beds were suitable for babies and children. There was eight cleanable parent beds. Resuscitation equipment was suitable for babies and children in each of the areas, including theatre recovery and outpatients department. Play equipment was suitable for the needs of children and had 'I am clean' stickers to show it had been cleaned. There was an area within the x-ray department which had been designed for children, but this had been temporarily closed due to the Covid-19 pandemic and toys removed.

Staff had access to specialist paediatric emergency equipment in all areas we checked. A paediatric resuscitation trolley was available on all inpatient and outpatient areas, and theatres. This was checked daily. All trolleys were secured and easily accessible in an emergency. All equipment we checked was in date.

Staff had access to emergency 'grab' boxes which had been stocked by the hospital resuscitation team. This contained lifesaving medication and equipment suitable for children

Staff disposed of clinical waste safely. Sharps boxes were kept in locked rooms on the children's ward, where children did not have access. All were dated and signed by staff for traceability.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff used the Paediatric Early Warning Score (PEWS) system to assist them with the early recognition of sick patients and management of any deterioration. Vital signs such as heart rate, respiratory rate, blood pressure, oxygen saturation temperature, and behaviour were used to assess each child's clinical status. This generated a scoring system which alerted staff to any potential deterioration. A Newborn early observation warning system was used on the neonatal unit which was specific to neonates (NeOWS). Staff alerted the nurse in charge of any triggers or scores which caused concern about deterioration. Medical staff would be called to review the child or neonate if required.

The ward manager conducted weekly reviews to check whether PEWS and NeOWS tools were being completed fully and alerts being followed up promptly. We looked at a snapshot of data on 18 October 2021 and found that matrons' monthly audits showed 100% compliance with criteria relating to identifying deteriorating patients and potential sepsis.

Services for children and young people

Staff received training in caring for children requiring high dependency care and paediatric intensive care and were able to look after very sick children and babies until they could be transferred to a local hospital with higher level critical care facilities. There was a transfer process in place which involved a nationally recognised specialist team retrieval to ensure safe transfer. The retrieval team worked well with the service and provided annual training sessions for staff. The clinical educator also delivered training on recognising the sick child.

Staff completed risk assessments for each child and young person on admission using a recognised tool. Staff received training on completing risk assessments which were in booklet form and included; cot sides assessment, self-harm risk, exposure to infectious diseases, Glamorgan scale (for pressure ulcer risk) Covid-19 status, and Paediatric Yorkhill Malnutrition scale (PYMS)

Staff knew about and dealt with any specific risk issues. Staff were vigilant in checking for signs of sepsis through the use of PEWS and NeOWS tools. There was a sepsis care protocol in place for the management of patients with presumed or confirmed sepsis. One-to-one care was provided for children who needed extra care or observation, such as children who were at risk of self-harm, and those in need of high dependency level one care.

Staff were supported to become competent with recognising a deteriorating child and identifying and escalating sepsis. Staff completed a specific competency booklet on sepsis and were required to complete e-learning.

The clinical educators supported new starters by delivering a sepsis session which showed how to recognise signs of sepsis, how to complete the trust paperwork and how to escalate concerns. Until new starters completed this assessment, they were required to escalate all patients with sepsis indicators to the nurse in charge

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a child or young person's mental health. Staff had access to rapid assessment with CAMHs when needed, either in person or via telephone. The children's ward had established a joint working initiative with the local NHS mental health and good links with the Child and Adolescent Mental Health Services (CAMHs). This was an improvement since last inspection. They had set up a new pathway for eating disorders and held weekly meetings with the local mental health NHS trust to review patients and were informed of any likely admissions requiring mental health support. Matrons also met regularly with the local mental health NHS trust to review all CAMHs pathways.

Children who were in the care of CAMHs at the age of 16 years onwards were able to continue being cared for on the children's ward during their transition up to the age of 18 years. A working group had been established with a matron as lead, to ensure a safe transition for this group of patients. This was an improvement since last inspection.

Staff arranged risk assessments for children or young people thought to be at risk of self-harm or suicide and sought help and advice from the safeguarding lead and medical staff where needed. Nurses used a risk assessment tool to assess patients who were at risk of suicide, self-harm or absconsion. This identified what level of staff monitoring was required to keep the patient safe from harm. Where necessary patients were allocated staff to provide continuous supervision.

Staff from the child and adolescent mental health service (CAMHs) provided support for patients who were at high risk of suicide or self-harm. CAMHs provided this additional support during day shifts.

Patients at risk of suicide, self-harm or absconsion were usually located in the patient bay nearest to the nurses' station to provide extra monitoring.

Staff did not use chemical restraint (such as sedatives) to restrain children and young people.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Information and discharge summaries were shared with GPs, health visitors and other relevant community teams. Staff held meetings with key community staff to plan for complex discharges.

Shift changes and handovers included all necessary key information to keep children and young people safe. We observed a shift handover and saw that all relevant staff were present and detailed information was shared, including the emotional wellbeing of children.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep children and young people safe. At the time of our inspection we saw that the wards we visited were fully staffed. Managers told us they had previously not had enough staff, but a recent recruitment had brought the staffing numbers to almost fully recruited to. Each area or department had staff who were suitably trained in children's or neonatal speciality which included paediatric life support. This included the children's ward, the neonatal unit, children's outpatients department, theatre and recovery area.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. Matrons held daily meetings across sites to review staffing rotas and this had meant some staff moved to other areas to meet the needs of other wards during the pandemic.

Ward managers planned staffing rotas and adjusted them according to the changing needs of the service and required staffing levels. The rotas were planned with one nurse to every four patients generally, one nurse to one patient for high dependency patients and one nurse to two patients for sick children. The nurse in charge was always a paediatric trained nurse and was supernumerary to enable them to oversee the running of the ward or unit. There were usually three paediatric trained or paediatric competent nurses and two non-trained staff on each shift. Paediatric nurses were nurses who had completed their nurse training specifically to care for children. All band 6 nurses had received high dependency unit (HDU) training. Adult nurses who worked in the service were given the opportunity to complete an extensive range of courses relating to children and neonates over the period of 12 months. They were assessed for competence in each area and once completed, the adult nurse held the status of 'paediatric competent'.

The ward manager could adjust staffing levels daily according to the needs of children and young people. Ward managers and matrons sometimes worked a clinical shift to cover rota gaps and absences. Regular bank shifts were used which were often filled by staff who worked on the ward. The clinical educator worked alongside staff and sometimes filled gaps in the rota.

During the Covid-19 pandemic, staff had been frequently re-deployed to other wards and areas to cover staffing gaps. The ward managers tried to ensure any redeployment was mainly within the family health services, however some adult nurses were moved to other services and some nursery nurses were asked to look after children in the emergency department. Most staff were happy with the support provided to assist them in a new area.

The number of nurses and healthcare assistants did not always match the planned numbers. These were displayed on wallboards. We looked at a snapshot of staffing rotas for the last six months and found staffing fill rate had varied each month on the neonatal and children's ward. This ranged from 75% to 100% for qualified staff and 43% to 89% for non-qualified staff. Managers and staff told us that staffing levels had improved, but that gaps were regularly filled by current staff and managers with very little bank staff usage. Ward managers, matron and the clinical educator stepped in to fill a clinical shift where there was a significant gap.

The service had low vacancy rates. There had been a recent staffing establishment review which had not been published at the time we inspected. The ward showed a small band 5 and band 4 vacancy (less than 1 WTE) and the neonatal unit were almost fully established. This was based on a revised staffing model which was awaiting approval at the time we inspected. Staffing within the neonatal unit met the British Association of Perinatal Medicine (BAPM) standards.

The service had low turnover rates. They had reducing sickness rates, although there had been a rise in sickness during the Covid-19 pandemic. Current rates of sickness were around 2%.

The service had low rates of bank and agency nurses. We looked at a snapshot of data on 18 October for agency and bank usage during a three month period June to August 2021 and found that agency usage was between 2.5 and 2.8% and bank usage was between 4.2% and 5% for the same period. Managers limited their use of bank and agency staff and requested staff familiar with the service and made sure all bank and agency staff had a full induction and were paediatric trained or paediatric competent. Ward managers, matrons and the clinical educator also stepped in to fill staffing gaps.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to fill the rotas but told us they were able to keep children and young people safe. There were eight consultants across the children's services with 1.9 WTE consultant vacancy across the trust. Consultant cover was in line with the Royal College of Paediatrics and Child Health (RCPCH). On call consultants were available within 30 minutes out of hours. Medical staff told us there were sometimes gaps in the medical staff rota for middle grade and junior grade doctors which had been filled with locums who were familiar with the service. There were no gaps in the consultant rotas. Medical staff were also needed to cover admissions in the emergency department. Staff told us they did not usually have a problem getting hold of a doctor when they requested one.

We looked at the most recent data provided by the trust and found that in August 2021the service had an overall vacancy rate of 13% for medical staff and turnover rate of 9%.

Sickness rates for medical staff were low reducing. Current sickness rate for August 2021 showed 3%. This had varied between 1% and 4% during the previous 12 month period.

The service had low rates of bank and locum staff. We looked at a snapshot of data for the previous 12 months and found that locum or agency usage was consistently around 5% and bank usage was consistently between 1% and 2% In August 2021 agency usage was 5% against a target of 2% and bank usage was 4% against a target of 2%.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The service used locums who were known to the service. Staff told us the locums were knowledgeable about the service and were assessible.

The service had a good skill mix of medical staff on each shift. There were always a consultant in charge, two registrars and two middle grade doctors on shift to cover the service.

The service always had a consultant on call during evenings and weekends. There was a 'hot week' consultant for children's and for neonates. There were always two registrars available and onsite each weekday and at the weekends there was one registrar on call and always available.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Records were a combination of electronic and paper. Care records and assessments were in booklet form and completed by a range of staff. All of the 10 records we reviewed, all were fully completed. Families were encouraged to bring the child's ongoing health record (red Book) with them into hospital.

Records were easily accessed by relevant staff, legible and comprehensively completed, stored securely and locked in cabinets

When children and young people transferred to a new team, there were no delays in staff accessing their records. Staff sent discharge summaries and information to health visitors, GPs, the CAMHs team and other relevant health care professionals electronically.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The pharmacy service to the wards ensured medicines' reconciliation was completed in a timely manner although this was not always possible at weekends as there is no pharmacy service to the wards.

The 10 medicines administration charts we looked at were completed fully, including allergies, weights and start, stop and review dates of antibiotics.

Ward managers reviewed medicines' charts daily and monitored adherence to policy and guidelines as part of their weekly spot checks. Matrons also included medicines checks in their monthly audits.

There was no specific policy within theatre for children and young people. However, theatres had a labelled paediatric emergency medicines pack with red grab bags. The packs were transferrable to any area caring for paediatrics and formed part of the theatre checklist prior to surgery commencing. Regular checking arrangements were in place for the packs to ensure medicines were maintained in-date. We reviewed the emergency medicines and found these were suitable for children and young people.

Services for children and young people

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines. Ward and medical staff spoke to patients and their parents about their medicines, occasionally a pharmacist would also speak to patients. Parents were encouraged to be involved in administering medicines to their children

The pharmacy team were available for advice and support during daytime hours.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Although the service did not have a dedicated pharmacist aligned to the service, they had a daily rotational pharmacist visit during the week, although this could be impacted by staffing levels. The pharmacist completed medicine reconciliation and prescription chart checks. Staff could get advice and support from a senior pharmacist if needed from Lincoln hospital.

Staff stored medicines securely in all clinical areas we visited. All medicines were locked in cupboards in locked rooms. Controlled drugs were stored correctly in locked cupboards and stock was checked by staff daily. New stock and unused stock was checked in and out by two qualified nurses and properly recorded. Medicine storage areas and cupboards were well organised and tidy and stock was regularly rotated. All medicines we checked were within their use by date. Staff kept records of medicines fridge temperatures and ambient room temperatures of their medicine rooms on the children's ward and post-natal unit. Checks were monitored by the ward sister as part of their weekly spot checks and by matron during the monthly audit.

Emergency medicines were correctly stored and easily assessible to staff where needed. This included theatre and recovery and outpatients department. The anaphylactic boxes in outpatients department were being reviewed by the new department manager. Currently they held auto-injectable devices in containers at specific locations which were easy for staff to grab if a patient experienced anaphylactic shock. Other medicines were accessed from the resuscitation trollies.

Staff followed current national practice to check children and young people had the correct medicines. Staff told us that medicines reconciliation was completed by pharmacists but not completed at weekends on the ward. Charts could be sent to pharmacy for this if needed but would be postponed until Monday if no-one was available.

Charts demonstrated medicines were prescribed and recorded appropriately. Medicines were stored securely, and we saw evidence of daily and monthly ward assurance regarding medicines management.

When children needed medicines to take home when being discharged, a medicines' chart would be taken to the pharmacy in the hospital for the prescription to be checked by a pharmacist. However, some medicines could be dispensed by staff from a small stock kept on the children's ward, which were checked with a doctor.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Staff were aware of the need to report medicines incidents and described sharing of learning across the trust. The pharmacy technician advised that alerts were handled trust-wide with senior members of the pharmacy team actioning them and recording this had occurred

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. This was part of the pharmacists' review. Ward managers checked the medicines' charts daily.

Services for children and young people

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. This was an improvement since last inspection. Staff understood their responsibilities to raise concerns, and there was now a positive culture of reporting incidents. Managers and staff told us there was a big improvement in incident reporting and learning from incidents. Qualified staff reported incidents and near misses in line with trust policy. Junior staff reported concerns to the nurse in charge and were informed of the outcome of these. Staff of all grades were able to give examples of an incident they had heard about because learning had been shared with the teams.

The service had no never events on any wards.

Staff knew to report serious incidents and understood the duty of candour. The duty of candour is a legal requirement; every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed governance meeting minutes and found that duty of candour had been used for each of the incidents discussed.

Staff received feedback from investigation of incidents if they had reported the incident. Learning from serious incidents was displayed on a clinical governance board in the staff area.

Staff met to discuss the feedback and look at improvements to children and young people's care. This was discussed at governance meetings where matrons and other leaders attended. Ward managers shared feedback with staff at ward meetings and briefings. Staff were aware of incidents which had occurred within the service.

There was evidence that changes had been made as a result of feedback. For example; a change to protocol means that a consultant always has to be present at any birth which is less than 32 weeks.

Managers investigated incidents thoroughly. Investigations were led by the risk team and the matrons. A 'learning from incidents' form was completed and learning was shared with staff by email, in team meetings, and on the clinical governance board in the staffroom. Children, young people and their families were involved in these investigations.

Managers took action in response to patient safety alerts. These were shared with staff by email and at ward meetings and daily handovers.

Safety thermometer

The service used monitoring results to improve safety. Staff collected safety information and shared it with staff.

Services for children and young people

Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provided a 'temperature check' on harm that could be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for all patients. Following consultation, the national collection of data stopped in April 2020 with the proposed developed of replacement data collection and reporting then impacted by the COVID-19 pandemic.

The service continually monitored safety performance and used the data to further improve services. Ward managers and matrons made a series of weekly and monthly checks and audits and shared this with leaders via a dashboard and with staff at meetings. The information was reported to the trust board.

Is the service effective?

Good 

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Management reviewed and updated policies and clinical guidelines as part of monthly governance meetings.

Policies and guidelines were accessed via the trust's computer system by all staff. National and local guidelines were used by staff which were also easily accessible from the computer. When policies were updated and changes made to national and local guidelines, the ward manager alerted staff to the changes and asked them to complete a signed sheet once they had reviewed the changes. The five policies we reviewed on the trust's computer system had been updated within the last 12 months.

The Bliss Baby Charter is a UK framework for neonatal units to promote best practice and a high quality of family centred care. There are seven principles that neonatal units are encouraged to work towards and undertake audits to self-assess compliance. During our inspection we saw the neonatal unit complied with most of the principles. Although there was no dedicated room for mothers to breastfeed or to express milk, there were a number of private rooms where mother could use.

The service took part in external reviews to assess their services. For example, the local mental health trust had undertaken a review of the children and young people's mental health service and care provision at Lincoln County. The report had not been published at the time of our inspection, however management told us they had received positive feedback with no significant areas for improvement

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff liaised closely with the local mental health NHS trust and with the Child and Adolescent Mental Health Services (CAMHs) to ensure children and young people with mental health issues had the most appropriate care. Where required, staff had access to rapid assessment with CAMHs. One to one care was provided where needed. The children's

ward was a 48 hour short stay unit, but where necessary, some children were able to stay for longer if they were being treated by a consultant from Pilgrim Hospital regularly, or if it was in their best interest to remain in the local area for a few more days. Children and young people who needed longer term care were cared for at other local hospitals and in the community.

At handover meetings, staff referred to the psychological and emotional needs of children, young people and their families. The local mental health NHS trust and CAMHs teams liaised closely with staff prior to planned admissions. Information about a child's mental health needs was shared at handover and staff were also alerted to additional needs in the child's record.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Patient's nutrition and hydration needs were assessed on admission. There was a choice of food to suit children's taste. Parents were encouraged to remain with their child at mealtimes. There were dedicated children's menus in place and older children could order meals from an adult menu if they preferred. A choice of baby foods was available for young children. Staff provided food to children outside of mealtimes as required, such as after a procedure.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed and used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. There was access to a dietitian for special requirements. Where children had swallowing difficulties, staff sought advice from the speech and language therapists who would provide support.

There was a nil by mouth policy in place for patients awaiting surgery and were designated, 'nil by mouth'. Cold meals were available to patients returning from surgery and didn't want to wait for a scheduled mealtime.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Picture charts were used where necessary to assess pain.

Children and young people received pain relief soon after requesting it. Staff were keen to ensure children did not suffer pain for longer than necessary. We saw that staff responded promptly to a child in pain during our visit.

Staff prescribed, administered and recorded pain relief accurately. Staff supported patients to receive suitable pain management when necessary. A dedicated pain management team were available for additional advice and support.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

The service participated in relevant national clinical audits. For example**;** the British Thoracic Society (BTS) national audit in management of community acquired pneumonia in children.

Outcomes for children and young people were positive and consistent with national standards.

Managers and staff used the results to improve children and young people's outcomes. These were discussed in governance and other managers meetings. For example. The trust submitted data for the Avoiding Term Admissions into Neonatal units Programme (ATAIN) to Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS). Data showed there had been 13 avoidable admissions between Pilgrim Hospital and Lincoln County Hospital between September 2020 and March 2021. The trust identified that the 'warm bundle' had not been followed in some cases which contributed to an avoidable admission. A warm bundle is an initiative to prevent hypothermia immediately after birth. Measures include providing a hat for the newborn and encouraging skin to skin contact with the mother. The trust made changes and ensured the warm bundle was now in the intrapartum booklet to be followed for every birth. They were monitoring their improvement action plan.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. This was an improvement since last inspection. A programme of audits had been developed. These were led by two members of the health and safety team who were managers. Doctors and junior doctors were encouraged to participate in clinical audits. Ward staff and matrons were involved in audits and checks such as accurate completion of PEWS and NeOWS charts, pain charts, and compliance with local protocols. We reviewed a snapshot of data provided by the trust for April to July 2021. Ward audits showed 100% compliance for most of the eight sections reviewed, including safeguarding and MCA checks, respect, deteriorating patient review, infection prevention and control, fluid balance, diabetes, and medication. There were some areas which scored 0% for example; privacy and dignity signs being used, skin care checks during board rounding, and having a care plan in place for nutritional needs. Staff said this may have been influenced by the acuity of patients cared for on the children's ward at the time of the audits. Matrons shared monthly ward assurance audits with the directorate to demonstrate performance.

Data provided by the trust showed that Medical staff conducted clinical audits to measure outcomes against the National Institute for Health and Care Excellence (NICE) guidelines and local guidelines. The service showed us 38 audits which had been completed within the previous 12 months. Clinicians made recommendations for change where guidelines were not being adhered to, and where improvements could be made. For example, where it was found that documentation needed to improve in an neonatal ultrasound scan audit, this was audited again to check it had improved.

Managers used information from the audits to improve care and treatment. Ward managers and matrons discussed the outcomes of weekly spot checks and monthly ward assurance audits and shared any actions for learning with staff at meetings and on governance wall boards. Managers also shared information at governance meetings and other senior meetings. Improvement was checked and monitored by the audit leads.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support and development.

The clinical educators had supported the learning and development needs of staff. The clinical educator was based on the ward and worked with staff from the ward, neonatal unit, theatre and outpatients department. They provided ongoing mentorship and support, monitored competencies and provided face to face training sessions for staff at all levels. They also supported staff with higher education degrees and apprenticeships.

Services for children and young people

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. All ward managers and band six nurses were paediatric trained or paediatric competent and had completed the high dependency unit (HDU) training. All other qualified nurses who were not registered paediatric nurses were expected to complete the paediatric competency programme. This was a suite of paediatric and neonate specific courses which provided them with the knowledge and experience to care for children and neonates. Nursery nurses completed paediatric or neonatal training.

Staff who cared for children in theatres, recovery and outpatients all received training to enable them to care for children and young people effectively. Knowledge and competencies were monitored by managers.

Managers gave all new staff a full induction tailored to their role and checked their competencies regularly. The trust had a preceptorship programme to support new starters, newly qualified nurses and nurses who had returned to practice. This enabled staff to be supported to develop their role specific competencies within the first 12 months of their role. We looked at the induction booklet and competency booklet and found these to be comprehensive. Nursery nurses also worked through a similar process to obtain and record their competencies gained within their role.

Consultants provided junior doctors with an induction upon joining the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Most staff said their appraisals were really beneficial and helped them to plan their development and career pathway. All staff we spoke with told us they had received an appraisal or were due one soon. Some had been rescheduled during the Covid-19 pandemic. Data provided by the trust showed that 68% of staff had received an appraisal within the last 12 months.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Data provided by the trust showed that, as of 30 September 2021, medical staff were 100% compliant with completing their appraisals.

The safeguarding team provided clinical supervision (support) sessions for staff where they could join a scheduled online session to talk about how they managed a safeguarding concern and to learn from others' experience. (Clinical Supervision is a formal, systematic and continuous process of professional support and learning, for practicing nurses, in which nurses are assisted in developing their practice through regular discussion with experienced colleagues with whom they can share clinical, organisational, developmental and emotional experiences.)

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Some nursery staff had been supported to and fully funded to complete their nurse training through an apprenticeship.

Managers made sure staff received any specialist training for their role. This included all courses relevant to caring for children and neonates, including life support training. The clinical educator conducted two training events each year focussing on using the PEWS and NeOWS tools and on recognition of the deteriorating child. Other relevant training was provided by external stakeholders such as the child retrieval team. Leadership and management course were also available.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Services for children and young people

Doctors and nurses reported effective team working and collaboration to provide care. Staff held multidisciplinary meetings to discuss children and young people and improve their care. Consultants, medical and nursing staff met with health visitors, children's community team, clinical educator, nursery nurses, outreach team, mental health colleagues and speciality medical staff such as specialist diabetes team and nutritionist, depending on the specific needs of the child. Daily consultant ward rounds included medical and nursing staff, physiotherapists, speech therapists and other health care professionals as required. The service had a family and baby (FAB) worker who worked closely with families in hospital and they also joined ward rounds and MDT meetings where required.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff regularly worked with the local mental health NHS trust and with the Child and Adolescent Mental Health Services (CAMHs) to plan for a child's admission or discharge. The service also worked closely with maternity and midwifery team, the safeguarding team, community nurses, and outreach teams.

Service leads collaborated with local teams, regional and national teams to form an East Midlands Neonatal Capacity Oversight Group (EMNCOG) to look at how neonatal capacity issues are addressed.

Staff within the neonatal unit worked with a neonatal network external to the trust. Staff could access an infant feeding coordinator as required to support the neonatal band six nurses who were also trained to support breastfeeding mothers.

We saw meeting minutes which showed representation from the trust at the East Midlands neonatal operational delivery network in July 2021. The meeting minutes demonstrated evidence of local trusts aiming to develop a consistent approach to providing care and treatment.

The trust was a participant in the Midlands and East Transition Network and East Midlands Transition Regional Action Group.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health. Staff had rapid access to the CAMHs team to make assessments. Children and young people who were suicidal received a risk assessment and were not admitted to the children's ward until suitable levels of supervision could be arranged.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants held ward rounds two or three times a day on the children's ward and neonatal unit. Neonates were also reviewed at least daily by a registrar. The hot week consultant reviewed patients at weekends. Children and young people were reviewed by consultants depending on the care pathway. For example, children with a long term condition or an eating disorder would see the consultant for their speciality.

The play therapists worked flexible shifts to support a wider range of hours including weekends.

Staff could call for support from doctors and other disciplines, including mental health services and some diagnostic tests, 24 hours a day, seven days a week. However, there were some tests such as ultrasound which were not always available at weekends. A business case was being formulated to move to seven-day service provision.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

Services for children and young people

The service had relevant information promoting healthy lifestyles and support on wards/units. There was a parents support board on the neonatal unit which signposted parents to various avenues of support. A similar notice board on children's ward provided a range of information for families.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff gave examples of where they had assessed a child's competence to make their own decisions about care and knew where to get advice and support if needed.

Staff made sure children, young people and their families consented to treatment based on all the information available, and in line with legislation and guidance. Patient records we reviewed had good documentation of consent, which included obtaining formal consent for procedures and surgery. They always checked with children before they undertook tasks such as administering medicines or taking bloods.

Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards and were aware of who to contact for support with this. MCA assessments were usually conducted by the CAMHs team for children. Staff told us they could usually access assessments quickly when needed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance. They usually asked a child's consent before carrying out a task such as taking blood and preferred to gain the child's consent and cooperation. For very young children, staff asked consent from a parent or carer. Consent for surgery and some other procedures were obtained formally in written form and recorded.

Managers monitored whether the correct procedure had been followed for children being detained under the mental health act and reported on this as part of the weekly quality and safety spot check. We were not able to review any patient records where staff had made an application for Deprivation of Liberty Safeguards as there were no children on the ward where this applied to at the time of our visit.

Is the service caring?

Good 

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Services for children and young people

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Staff were very aware of how concerned families might feel about their child and took time to explain things thoroughly. There was a play therapist who was frequently utilised to help children and young people with distraction techniques and building trust prior to a procedure such as taking blood.

The service employed a family and baby worker (FAB) who worked with families on the neonatal unit to provide support and guidance in helping them to understand their child's condition and what support was available. The FAB worker liaised with nursing staff and other agencies to ensure the right help and advice was provided.

Children, young people and their families said staff treated them well and with kindness. All 10 families we spoke with highly praised the nursing and medical staff.

The service conducted an annual children's and young people's patient experience survey. The overall findings from the 2020 report showed a positive response about the care they received in hospital.

Staff followed policy to keep care and treatment confidential. Conversations about care and treatment sometimes took place at the bedside, however, parents were invited into a private room to discuss sensitive issues. Most conversations took place in patient rooms where the door was closed. Conversations could not be overheard.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. Staff took time to ensure young people understood their care and encouraged them to contribute as much as possible in their care plan.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. They took time to listen to parents and carers about what was important to them and their child.

In the neonatal unit, staff had implemented an electronic 'ear' in the nursery. The device was programmed to signal a red light when noise levels increased above a certain level. It was thought that noise levels need to be moderated for neonates to keep them feeling safe and happy.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Nurses and medical staff took time to listen to parents, and where a family was particularly upset or bad news was being shared, staff would utilise a private room where families could have privacy to talk. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. The play therapist assisted with children who needed help to stay calm. All staff understood the need to support children who were distressed and ensured their privacy where possible.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's, wellbeing. The FAB worker was also available to listen to parents and provide help and advice.

Services for children and young people

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. They understood that some parents preferred to carry out some care tasks for their child themselves. They encouraged parents to take part in their child's care and carry out some of the complex care interventions. Parents received training, guidance and support to carry out care such as tube feeding and utilised a set of parent competencies in a booklet to enable parents to carry out as much or as little as they felt comfortable with.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Pictures and signs were used to help children's understanding.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Cards and comments made to staff were extremely positive and praised staff at all levels. Parents could not speak highly enough about the care their child had received. All the families we spoke with were extremely happy with their child's care and with the all aspects of the ward environment and facilities provided. There was just one exception where a parent said the evening menu could be improved.

The service provided parents rooms where parents could stay overnight with their child on the ward. There were six parent beds available where a parent could sleep next to their child's bed or cot. Parents had access to a parents kitchen and rest room, shower facilities and lockers. They were provided with basic food and refreshments and facilities to make hot drinks.

The neonatal unit had two transitional rooms where parents stayed with their neonate for a few days to get accustomed to caring for their very tiny baby. The room was furnished with a double bed, wardrobe, kitchen, lounge area with TV, and bathroom facilities. There was room for siblings to visit. Parents still had access to nursing and medical staff on the neonatal unit whilst staying in the transitional rooms.

Is the service responsive?

Good ↑

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The children's ward had changed from being an inpatient ward to a 48 hour assessment ward. This meant that more children could be seen quickly for conditions that required a short stay in hospital and more complex cases were cared for at Lincoln County hospital or at another NHS trust where level two care was available.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. This was checked by ward managers during their weekly spot checks. There were enough single rooms to ensure boys and girls did not share accommodation.

Services for children and young people

Facilities and premises were appropriate for the services being delivered. The service had sufficient isolation rooms and child specific facilities and furniture. There were private rooms available to speak with families. There were milk kitchens for feed preparation and sufficient facilities and equipment to assist breastfeeding mothers. There were play facilities and toys for children of all ages and a sensory room. Facilities for parents who wished to stay overnight were very well furnished.

Theatre services and recovery area had improved facilities for children so that children were cared for separately to adults. This was an improvement since our last inspection.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. This was through links with the CAMHS service and community mental health teams.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services.

A transition group was set up to drive improvements in transition of care for children up to the age of 25 years. The trust appointed a transition nurse for children with complex health needs, a consultant lead for transition and senior manager for transition from adult services. The trust has established links with the national lead transition nurse and meets with the Regional Nurse Advisor for Transition. The service has raised the profile of transition services with the trust and is progressing plans to improve transitional care for more children and young people. This is an improvement since last inspection.

Currently, children with diabetes received shared care from the age of 16 years. Children's and adult diabetes services held multi-disciplinary team (MDT) meetings to plan care and ensure a smooth transition from children's to adult services. Young people were able to transition to at their own pace in managing their condition as a young adult with supervision in an adult environment relevant to their specific needs.

Managers monitored and took action to minimise missed appointments. Outpatients managers checked missed appointments daily and contacted the child's parents or carers and the relevant health visitor if a child missed two appointments.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long term conditions received the necessary care to meet all their needs. Although the children's ward was for stays of 48 hours or less, children with a special need or long term condition were able to stay longer if it was in their best interest to remain in a familiar environment. The criteria for this was that the child needed to be treated by a consultant from Pilgrim Hospital and known to the service.

Staff liaised closely with CAMHS and community mental health teams to plan admissions and ongoing care for children with a mental health issue or a learning disability. Staff had forged strong links with children and adolescent mental health services (CAMHS) and the local mental health NHS trust to establish improved care pathways for complex problems, including for eating disorders.

Services for children and young people

Staff took extra care to ensure that children with a learning disability were at ease in the environment and took time to communicate with them.

Staff followed individual community care plans in order to support patients with learning disabilities. They highlighted the patients' specific care needs and preferences. Staff could access the local community learning disabilities team if they required additional support or guidance to meet patient's individual needs.

Play leaders provided support for all children on the wards and in outpatients. They particularly focused on patients who had additional needs as requested by nursing staff to support and/ or distract patients from unpleasant procedures or aspects of care. The play therapists were proactive and knowledgeable about how to support the needs of individual patients. They took time to get to know patients and work with them in ways which suited the patient best.

Wards were designed to meet the needs of children, young people and their families. The layout of the children's ward and neonatal unit provided good sight of children who needed most support. The neonatal unit was a nursery whereby cots and incubators were in one large room with sufficient space between to allow for equipment and for parents to sit with their newborn. There was also an isolation room at one end of the nursery and the sister's office at the other. There were suitable furniture and facilities for parents including lockers, a kitchen, restroom and two full parents transition rooms with kitchen and ensuite facilities.

Equipment, toys and facilities were child friendly on the children's ward and there was child friendly signage. Entrances to the ward and neonatal unit were locked and only accessible via swipe card for staff. Parents and visitors were required to use the call bell to enter.

Staff supported children and young people living with complex health care needs however did not use 'this is me' type documents.

Staff followed individual community care plans in order to support patients with learning disabilities. They highlighted the patients' specific care needs and preferences. Staff could access the local community learning disabilities team if they required additional support or guidance to meet patient's individual needs.

Play therapists provided support for all children on the wards and in outpatients. They particularly focused on patients who had additional needs as requested by nursing staff to support and/or distract patients from unpleasant procedures or aspects of care. The play therapists were proactive and knowledgeable about how to support the needs of individual patients. They took time to get to know patients and work with them in ways which suited the patient best. For some patients, the play leaders provided age appropriate toys and supported play, for other patients the play therapists supported with homework or communication skills. Play therapists also went to outpatients department to support and distract patients when needed.

Staff were aware of the communication needs of children and young people with a disability or sensory loss and used pictures to help them understand where needed. The service had recently installed a sensory room specifically to help children and young people with sensory loss.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. However, these had been removed during the Covid-19 pandemic.

Services for children and young people

Children, young people and their families could get help from interpreters or signers when needed. Staff gave examples of using an interpreter for a different language but could not remember recent examples of using an interpreter for signing.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. There were choices available to suit different preferences. Meals were mainly hot meals at lunchtime and sandwiches and cold food at teatime. There was a kitchen on the ward to prepare simple alternatives such as toast.

There was an 'All about me' booklet which was available for children to complete. This was a trust-wide booklet and not specific for children. However, it contained useful information about carers, diet, interests and other items which were relevant to children and was in an accessible format.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. The children's ward was a 48 hour assessment unit where children and young people attended for short term treatment or anticipated a short recovery time from surgery. Some children who were known to the service were able to stay longer. For example, children with a long term condition such as diabetes and children with a mental health disorder awaiting a speciality bed in the community. Staff worked with other agencies to ensure a smooth transition to ongoing care when this was needed.

The neonatal unit utilised two transition rooms for parents to stay with their newborn to help them adjust to caring for their child. Leaders had implemented a project with a community team where they worked closely with specialist community nurses to enable neonates who required ongoing specialist care such as continuous oxygen, could be discharged early with the support of a specialist community nurse.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. Managers and staff told us that children were always seen by a doctor within one hour of admission and within 14 hours by a paediatric consultant. Staff told us that children were always seen by a doctor within an hour of admission and that a consultant visited every day. Outpatients manager monitored wait times for children in the department.

Managers had developed or were in the process of developing pathways with partner organisations to improve access to care. For example, oncology patients had open access to receive care or treatment for any medical concerns. An eating disorders bypass pathway had been set up for patients who had a referral from their GP or another hospital.

Managers worked to keep the number of cancelled appointments/treatments/operations to a minimum. The Covid-19 pandemic had impacted on waiting lists for treatment and staff were working to resolve this.

Staff did not move children and young people between wards at night and only transferred children and young people to other services in the event of an urgent clinical need. Where a very sick child was transferred, a specialist transfer

team was utilised to retrieve and transfer the child. Staff worked closely with the specialist transfer team to ensure the child was properly prepared for safe retrieval and transfer. Data provided by the trust showed that in the period between October 2020 and September 2021 the service had transferred 39 children to other NHS providers. This included three children to NHS high security psychiatric accommodation.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning was commenced on admission and in conjunction with parents or carers.

Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs. Staff worked closely with CAMHS and other community teams to ensure a safe and appropriate discharge.

Staff supported children, young people and their families when they were referred or transferred between services. The service didn't provide oncology services and arranged for these services to be carried out in the community or at a local hospital.

Managers monitored patient transfers and followed national standards. Transfers only occurred for clinical reasons where a child required specialist services not provided onsite.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. All the parents we spoke with said they knew how to complain if they needed to. The trust shared data which showed they had 63 complaints made to the family health division during 2020/21. Only one of the complaints related to the children's services at Pilgrim Hospital.

The service clearly displayed information about how to raise a concern in patient areas. This was provided in a family folder which was handed to all parents to read.

Staff understood the policy on complaints and knew how to handle them. They knew how to acknowledge complaints and told us that children, young people and their families received feedback from managers after the investigation into their complaint. Learning from themes were shared at monthly divisional meetings, specialty governance meetings, and patient experience group. Staff at ward or department level heard about trends and themes at staff or ward level meetings and via the governance wall boards.

Learning was also shared through staff bulletins (Learning to Improve Bulletins), monthly divisional integrated governance reports, and complaints and the Patient Advice and Liaison Service (PALS) reports.

Managers shared feedback from complaints with staff and learning was used to improve the service. Although there had been no complaints that staff could remember, they told us that learning from complaints was shared based on other areas within the service.

Staff could give examples of how they used patient feedback to improve daily practice. The service had purchased lockers for parents, so they didn't have to carry coats and bags into the nursery on the neonatal unit.

Services for children and young people

Is the service well-led?

Good ↑↑

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The family health division had a leadership team which managed activity across both sites. Division leaders told us they worked well with each other and understood the challenges they all faced around quality and sustainability of services, including staffing issues.

Local leadership was provided by matrons, ward managers and department managers. Staff were extremely positive about their local leadership team and said they were visible and supportive. Matrons worked across both hospital sites and visited Pilgrim Hospital at least weekly to ensure they were visible and accessible to staff who required support. Ward managers said their matrons were in contact daily by phone and could contact the matron from the maternity division when their own matron was not at work. Senior leaders including the interim head of midwifery and nursing were also visible and made regular visits to the service.

Staff said local senior leaders were visible and would visit the ward or department and a duty manager was always available out of hours if they needed support and guidance.

At the time of our inspection, a band seven manager had just been appointed to run the children and young people outpatient services across the trust.

Managers supported staff to develop by securing funding for internal and external courses, encouraging continued professional development.

Staff told us that the chief executive for the trust had shared information effectively during the Covid-19 pandemic enabling staff to be regularly updated.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a trust wide strategy for 2020 to 2025. This included the paediatric service provision. A family health divisional strategy highlighted specific goals for the children and young people service.

Most staff were aware of the vision and values of the trust and were able to give examples of how their work reflected the values. Staff articulated their values centred around putting the patient and their families first and being the most important person in the hospital.

Services for children and young people

Staff were aware of the service's vision and strategy to improve services for children and young people since our last inspection, which included a recruitment strategy, forging stronger links with stakeholders in the community, implementing a transition programme, and creating new pathways for patients with mental health needs and certain long term conditions.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Senior leaders told us that local leadership at Pilgrim Hospital had improved over the last two years and was currently very robust and dynamic. Staff at ward level confirmed this and described leadership as enthusiastic and effective. Senior leaders had considered their succession planning requirements and offered leadership development to staff and had recruited into clinical leadership roles. They were actively recruiting to additional clinical lead roles for governance and for audit as part of their ongoing development plan.

Staff said they felt respected, valued and supported. They told us about how they had risen to the challenges of the pandemic in order to do their very best for patients. Many staff had been temporarily re-deployed in areas they not previously worked in but all said they were focused on the needs of patients at the time. Leaders were aware of the changes that had been required in responding to the COVID-19 pandemic had impacted on staff morale and wellbeing. Managers had tried hard to redeploy staff within the family health division. Some adult staff had worked on the maternity unit whilst some nursery nurses worked in the emergency department caring for children. When some staff reported that they didn't feel well-prepared to work in other areas, managers devised a checklist to identify which activities a children's nurse could be expected to complete in an adult area. Managers conducted risk assessments for staff which included mental health assessments prior to redeployment. Any staff member who felt strongly that they were unable to work in another area were retained on the ward or unit.

Counselling and formal support from colleagues and managers was available to all staff.

There was an open, supportive culture across the service. Staff of all grades were encouraged to speak up about any concerns and ideas for improvement were encouraged. All staff told us they felt part of the team and included in meetings and decisions about the future. Patients and their families were also encouraged to talk to the staff about any concerns they had. When something went wrong, patients received an apology and were told about any actions to prevent something similar happening in the future.

Staff told us they were proud to work for the trust and had a common sense of purpose. There was a culture of collective responsibility between teams and services, and we saw positive and supportive interactions between all staff.

Staff we spoke with said they enjoyed working on the ward and felt they were part of a good team. They told us they were supported to speak up and rise concerns without fear of reprisals.

Staff told us they felt supported by managers.

Managers and staff were given the opportunity to complete mental health first aid training to support patients and colleagues.

Services for children and young people

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a governance system in place where the trust used established systems, processes and a suite of clinical policies in conjunction with the National Institute for health and Care Excellence (NICE) guidelines to provide a set of standards for wards and departments to comply with during each stage of the patient's journey. Policies were regularly reviewed. This was an improvement since last inspection.

Children and young people services were part of the family health division. Leaders attended a variety of governance meetings where they discussed progress across the service to ensure information was escalated and cascaded to all staff within the service. These were trust wide meetings and included representatives across sites including Lincoln County Hospital and Pilgrim Hospital in Boston. Divisional leads had good links to the executive team enabling them to escalate information in a timely manner.

The family health division reported key quality, safety and performance information to the trust board monthly. At divisional level, a number of governance, finance, performance, safety, quality and risk meetings took place. These were attended by medical and nursing leaders and included relevant staff at different levels. Staff at ward level told us that key information was usually shared with them at ward meetings. However, ward meetings had been limited during the Covid-19 pandemic and were not fully utilised at the time of our inspection. Meetings were most via digital platforms and attended by the relevant leads and there was evidence of information sharing and escalation of risks, with actions to mitigate them. Consultants presented cases they had analysed because something had gone wrong. Learning was shared with the senior team. Other regular agenda items included infection prevention and control, policy and protocol review, audit outcomes and safety alerts.

Divisional level meetings were held monthly which incorporated other services such as maternity in addition to children and young people.

Paediatric, community paediatric and neonate unit governance meetings were held monthly. Divisional level business managers attended all three of these meetings as did the senior pharmacist to ensure continuity.

Consultants held regular meetings to discuss performance, clinical pathway planning and staffing.

Local team meetings were held, however, these had been significantly reduced over the Covid-19 pandemic. Staff told us there had been one meeting held via videoconferencing within the past six months. However, wider staff members could attend governance meetings to hear updates.

We reviewed a sample of meeting minutes for May, June, July, August and September 2021 and saw these were well attended. Regular agenda items included risks, incidents, serious incidents, complaints, staffing concerns, service improvements and other ongoing concerns.

Managers invited all staff to a monthly governance meeting. Other regular attendees included the pharmacist who oversaw the children's and young people service, the matron for the area, business managers, ward managers, clinical

educators and medical staff. Where ward-based staff could not attend, any information and learning was cascaded down. For example, changes to the trust policy on fever in the under-fives were shared via a PowerPoint presentation and an audit which was emailed to all staff. Where managers required confirmation that information had been read by the wider staff group, they requested confirmation via either email or a signature sheet.

Matrons and medical staff attended perinatal (during pregnancy and up to a year after giving birth) mortality and morbidity meetings and shared findings within governance meetings.

Safeguarding leads for the division demonstrated oversight of the children and young people service; they undertook record audits, delivered training and shared information to ensure all staff were aware of their responsibilities.

The service had identified areas for improvement and action plans were in place to monitor progress. Performance information was shared with the senior leadership team by the Director of Nursing.

The matron and ward manager displayed a clinical governance board which was accessible to staff. This contained information about open incidents and themes, risks on the incident reporting system and on the service risk register, and complaints and compliment themes. This had been updated for October 2021 at the time of our visit.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Risks, issues and performance was discussed at trust board level, divisional level and directorate level and information shared with staff at ward level. Each directorate maintained its own risk register, which included local ward level risks.

The family health risk register showed the highest risks for the service being related to delays and challenges in delivering services to vulnerable groups of patients, as well as challenges with staffing during the Covid-19 pandemic. The risk relating to adherence to policies and protocols had reduced over time due to actions the service had taken to improve governance over the previous two years.

The service had a corporate risk register for the children and young people service as a whole. This included one risk specific to Pilgrim Hospital. The remainder were more generalised potential risks rather than specific to the current status of the service. Mitigating actions were listed to reduce risks however these were not specifically allocated or dated therefore it was not possible to tell from the risk register if these actions were being delivered at the time of inspection. Despite this, we saw managers including the directorate leadership team, matrons and ward manager had a good understanding on active risks to the service at the time of inspection and were able to talk about how these were being specifically mitigated.

Managers identified nurse staffing and agency spend as a risk across the sites, however, agency spend at Pilgrim Hospital was minimal. Managers had recruited staff to mitigate staffing issues and had plans to prioritise certain posts such as specialist nurses. Managers also supported the internal development of staff already employed to support staffing and retention.

The service management team identified referral to treatment times for children and young people as a risk to the service across both sites. Prior to the pandemic, the division performed much better indicating the pandemic had negatively impacted upon the division's ability to deliver this target rather than the division generally underperforming.

Service management reviewed incidents to identify themes, share immediate learning and produce root cause analysis reports. This enabled a better oversight of areas of concern, such as medicines' management. Matrons for the service told us of findings and actions from this process in order to reduce the number of incidents. We saw evidence of this within governance meeting minutes. The pharmacist with oversight for children and young people's services attended governance meetings.

Senior nurses and above received training on risk and incident management.

Band seven nurses (ward manager and clinical educator level) held weekly meetings to share information and to discuss risk and incidents.

The trust did not routinely monitor or audit waiting times for children to have a medical review as per the Royal College of Paediatrics and Child Health (RCPCH). This meant the trust did not have full oversight or assurance against this measure.

Although identified as a risk, the trust did not routinely capture the numbers of patients admitted under children and adolescent mental health care services (CAMHs). The matron had plans to start monitoring this data as part of a developing partnership with the local CAMHs.

Managers discussed the risk of respiratory syncytial virus (RSV) in terms of winter planning and Covid-19 recovery during oversight meetings.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Patient data was constantly updated electronically, such as the recording of physiological observations and medicines administration. Staff were aware of how to use and store confidential information. Managers used dashboards to manage and share performance metrics and audit outcomes. Notifications were made to external organisations when required.

Staff attended daily handovers with their colleagues and the named nurses of patients they were due to support each day. This provided them with the information they required to meet the specific needs of each patient.

Performance information was shared and discussed at ward meetings so staff could identify any actions required to improve patient care.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged with patients through gathering feedback in a variety of ways. Staff could capture patients, parents or carers views whilst on the ward via an electronic device. They also participated in the national Friend and Family test.

Services for children and young people

The service liaised with external organisations to improve care and treatment for children and young people. Service representatives attended the East Midlands neonatal operational delivery network meetings. A matron had developed positive links with the community child and adolescent mental health service (CAMHs) to support patients more effectively. Some staff went into local organisations such as schools to promote services and to build trust in healthcare staff.

Matrons completed monthly audits which included patient and staff experience. Staff audits reviewed appraisal rates, sickness rates and staff health and wellbeing.

Data from the trust showed an August 2021 survey of the junior doctor induction to the service which showed attendees found the induction a helpful and positive process.

The service worked with the University of Lincoln to create a branding and a colour scheme. They asked service users and staff to judge and choose the most appropriate design and colours. The ward will be painted in colours chosen with autistic service users in mind as research suggests that certain colours increase positive behaviours in children.

The service engaged with other agencies to improve performance and had asked the sick patient transfer service to perform a peer review. The results were not available at the time we visited but managers had received very positive initial feedback from the review.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

The divisional and local leaders took action to make improvements in the running of the service. They had regular meetings where learning was discussed, including quality and governance meetings and daily safety huddles. There were specific meetings to discuss and learn from audit outcomes.

The management team told us that a programme of continuous improvement was underway for the service trust wide in order to mitigate risks and improve patient pathways. They spoke openly of developing the service and presented as committed to raising the profile of the children and young people service within and outside of the trust.

The senior leadership team for the service shared innovative ways to improve recruitment. This included using the certificate of eligibility for specialist registration (CESR) route to recruit doctors which enables junior doctors from abroad to go on the specialist register held by the General Medical council (GMC) as a consultant.

At the time of our inspection, medical staff told us there was no active research happening, however, a newly appointed consultant had begun to involve the service in some research projects.

The matron overseeing the paediatric wards across sites had implemented a number of initiatives. These included engaging with a local university graphic design course to design and create unified branding and décor for wards and the paediatric area within the Emergency Department. They had also developed, in conjunction with the local children and adolescent mental health service (CAMHS) pathways to support patients who presented with either diagnosed eating disorders or with disordered eating. They had also recently implemented a new initiative to enable early discharge of neonates with complex needs by working with specialist community services to provide clinical advice, monitoring and support at home. This meant that neonates who would usually continue to receive oxygen therapy and other clinical support in hospital, were able to be cared for at home much sooner.

Services for children and young people

Staff within the children and young people service had opportunity to engage in continued professional development. We saw funding had been procured for autism training and advanced paediatric life support training (APLS). Some staff were being supported to gain formal university qualifications such as completing a paediatric nursing degree to develop their career.

Nursery nurses were offered the opportunity of funded apprenticeships which included being able complete training to become a registered paediatric nurse.

Lincoln County Hospital

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Description of this hospital

Lincoln County Hospital serves the city of Lincoln and the North Lincolnshire area. It provides all major specialties and a 24-hour major accident and emergency service.

Between 5 and 8 October 2021, we inspected four core services provided by the trust at this location. We carried out an unannounced inspection of urgent and emergency care, Services for children and young people, Medical care (including older people's care) and a focused unannounced inspection of Maternity.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate. We have therefore rated the key question of safe in Maternity services as requires improvement. All other ratings in Maternity services remain unchanged.

Maternity

Good ➔➔

Is the service safe?

Requires Improvement ➔

Environment and equipment

The maintenance and use of facilities, premises and equipment did not always keep people safe.

Some areas within the maternity environment had not been adequately maintained which posed a safety risk to women, visitors and staff. For example, on the maternity ward, large wooden splinters were visible on at least three door frames leading to patient areas and two bath panels were broken and cracked. Staff told us these safety concerns had been escalated to estates but no action had been taken to make these areas safe. We escalated this during our inspection and following our inspection we received evidence to show immediate action had been taken to address these safety concerns.

Equipment that was in poor condition or non-functional was not always reported in a timely manner to enable repairs to be made. For example, women on the maternity ward told us and we saw that the window blinds in their rooms were not fully functional. They told us this impacted on their wellbeing during their admission as it affected their sleep and their privacy. We checked the blinds in 11 rooms on the maternity ward and found that none of the blinds were in full working order. Staff told us they had reported these broken blinds to the estates department. However, evidence that these had been reported by staff on the maternity ward was not provided to us. We also identified the bath lift on the labour ward was not working. We escalated this during the inspection and staff told us they were not aware that it was not working. Following our inspection, we asked for evidence to show this bath had been reported to estates. The trust evidenced this had been reported eight days after our inspection. This meant the concern regarding the bath lift was not reported in a timely manner placing women at risk of receiving inappropriate and/or unsafe care.

Facilities and equipment concerns were not always responded to in a timely manner to ensure the environment met the needs of women. One woman on the maternity ward told us the toilet in their room was out of order. Records showed this toilet had been made out of order due to a broken toilet seat which had been reported to estates in May 2021. Staff told us this room would be utilised for women with infectious conditions. However, women in this room would have to use communal toilets and bathrooms whilst the toilet was out of order, increasing the risk of spreading infections. We saw two sinks on the maternity ward had been reported to estates in July 2021 because they were blocked. These sinks had still not been fixed at the time of our inspection. Not addressing these concerns in a timely manner posed risks around infection prevention and control as less sinks were available for staff and women to wash their hands.

We found that equipment was not always used in accordance with manufacturers guidance. Fetal monitoring belts were being laundered and used with multiple women. This was against manufacturers guidance which stated these belts were not to be laundered and were for single person use only. This meant the belts were at risk of wear and tear and also at risk of becoming contaminated with infectious materials. We escalated this to the trust who immediately sought advice and stopped this process.

The service had plans to improve the estates and facilities at this hospital by 2024. This included renovating and relocating the wards. No specific start dates for this work had been agreed at the time of our inspection.

Maternity

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Staff used the Modified Early Obstetric Warning Score (MEOWS) and Paediatric Early Warning Score (PEWS) which are nationally recognised tools to identify women and babies at risk of deterioration and escalated them appropriately. Records showed and we observed timely and appropriate responses to rising early warning scores, ensuring women and babies were escalated appropriately in the event of clinical deterioration.

Staff completed risk assessments for each woman on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk factors included; blood clot risk, carbon monoxide risks and a general risk assessment relating to whether the pregnancy was high or low risk. These risk assessments were recorded in both electronic and paper records, and were used by community and acute staff. This ensured that staff always had access to this information in the event of an emergency. We saw this was effective as staff used these paper records when the electronic records system was unavailable during part of our inspection.

Staff knew about and dealt with any specific risk issues. For example, we saw when women were identified as having a risk of developing blood clots, appropriate action was taken to reduce this risk.

In line with national recommendations, a ‘fresh eyes’ approach to cardiotocography (CTG) interpretation was in place for those women who required continuous CTG monitoring. A CTG measures a baby's heart rate and monitors the contractions in the womb (uterus). Fresh eyes checks were performed every hour by a second staff member during continuous fetal monitoring. This provided a safety net to reduce the risk of misinterpreting a CTG reading. Records we reviewed showed appropriate monitoring, interpretation and escalation of CTG readings.

Staff completed a mental health screen on all women and arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Every woman’s’ risk of domestic violence was also assessed during every appointment when this was appropriate. Risks associated with mental health and domestic violence were clearly recorded in the patient records and flagged on the electronic patient record system. Referrals for specialist support were made for women who were at risk of or experiencing domestic violence.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman’s mental health.

Records showed that staff consistently performed swab counts in theatre and completed the World Health Organisation (WHO) checklist in line with National Patient Safety Agency (NPSA) guidelines. The WHO checklist is a global initiative that was designed and implemented to improve surgical safety. Regular WHO checklist audits were undertaken and recorded electronically which showed 100% compliance with the WHO surgical safety checklist.

Shift changes and handovers included all necessary key information to keep women and babies safe. Staff discussed all inpatients at the midwifery handover and the multi-disciplinary team (MDT) handover meetings. This ensured midwives and medical staff had access to key information to keep women and babies safe when handing over their care to others.

Maternity

Staffing

The service had some staffing vacancies. However, shifts were covered to ensure there were enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had some staffing vacancies. Staffing data for September 2021 showed the service had 7.8% medical and 6.4% midwifery and support staff vacancies. Ongoing recruitment was in progress to address staffing vacancies and new staff were due to start working at the service before the end of the year.

Staffing rotas for August and September 2021 evidenced that actual staffing numbers did not always meet planned numbers. Staff told us this was due to sickness. However, staff also told us that if patient acuity meant any staffing gaps needed to be filled to ensure the safety of women, those shifts were always covered. Cover was provided by staff picking up additional shifts, managers and specialist midwives. Trust data showed that one to one care during labour was provided to women 100% of the time between November 2020 and October 2021.

Managers calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. The birth rate plus tool was used to measure and review acuity and in workforce planning. At the time of our inspection, the service (which included Pilgrim Hospital and Lincoln County Hospital) was staffed based on the trust's Birth rate Plus recommendations of 2017. Managers have since completed a birth rate plus review which recognised an increase in acuity of women admitted to the service. This report was received by the trust in March 2021. This review identified a shortfall of 3.51 whole time equivalent (WTE) midwives. A bid for the funding for the posts was in progress.

A continuity of carer (CoC) review had also been completed. CoC is an approach that aims to provide consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey. The trust had submitted a bid to fund an additional 8.69 WTE staff to support the rollout of CoC to 35% of women.

The ward managers could adjust staffing levels daily according to the needs of women. Staff reviewed acuity every four hours which meant adjustments to staffing could be made in response to an increase in acuity. Staff told us that when acuity increased, additional staffing was provided to keep women and babies safe.

Consultants and anaesthetists were always available. This included the provision of out of hours on call cover which staff told us was always provided in a timely and responsive manner.

Managers made sure all staff had a full induction and understood the service.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored securely or in line with manufacturers guidance

Staff followed systems and processes when safely prescribing, administering and recording medicines. Medicines administration records (MARs) contained patients' weights, allergies and the frequency, dosage and administration route of the medicines were clearly recorded.

Medicines, including controlled drugs were not always stored securely. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. On two occasions during our inspection

on the maternity ward, we were able to access medicines in unlocked drawers in an unlocked room. This room was accessible from two separate corridors meaning patients and their visitors could enter the room potentially accessing the medicines. We escalated this twice during our inspection to managers which resulted in the medicines being moved each time.

Women could not be assured that their medicines were effective as staff were not ensuring medicines were being stored in line with manufacturers guidance. Temperature monitoring of medicines stored at room temperature were not being monitored despite staff telling us the rooms were consistently warm. We escalated this to managers on the labour and maternity wards. Temperature monitoring was immediately put in place on the labour ward. However, when we returned to the maternity ward on the second day of the inspection temperature monitoring was still not being completed.

Incidents

Most staff recognised and reported incidents and near misses. However, systems in place to share learning from incidents were not consistently followed. However, managers investigated incidents appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

Most staff knew what incidents to report and how to report them and we saw evidence that incidents were being reported however, two of the 14 midwifery staff we spoke with told us they did not always report incidents relating to safe staffing. One staff member told us their manager had told them not to report safe staffing incidents and the other staff member had not recognised that the incident they described to us was potentially a reportable incident.

The systems in place to ensure there was shared learning from incidents were not consistently followed. These systems included emailing all staff with this learning and reading out lessons learned and safety information in every handover. This safety update was referred to as a 'newsflash'. Staff did not read the newsflash out during the handovers we observed during our inspection which was not in line with the trust's agreed processes. This meant there was a risk that staff may not access learning from incidents in a timely manner if they were unable to access their emails.

Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong.

Staff told us that managers provided debriefs and support after any serious incident.

Staff met to discuss incident feedback and look at how they could improve patient care. For example, maternity staff reviewed CTG's with consultants and learned from incidents where CTG interpretation was incorrect. This learning took place during weekly CTG meetings. This showed the service had learned from previous serious maternity incidents where CTGs had been incorrectly interpreted to prevent recurrence.

The service had no maternity never events in the 12 months leading up to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Staff also worked with external agencies to ensure learning from incidents was shared. The service referred relevant incidents to the maternity Healthcare Safety Investigation Branch (HSIB). Staff used recommendations from HSIB reports to improve patient safety.

Maternity

Is the service effective?

Good

Evidence based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed 11 clinical policies relating to the maternity department. This included; diabetes in pregnancy, hypertensive disorders in pregnancy and sepsis guidance. These were all up-to-date and reflected best practice guidance and national standards.

Managers used audits to check that staff followed agreed clinical guidance. Audits appropriately identified areas of compliance and areas for improvement. Audit areas included; assessment and management of sepsis, fetal monitoring and catheter care.

In accordance with national guidance, staff routinely referred to the psychological and emotional needs of women. We observed nursing and multidisciplinary handover meetings which evidenced this.

Competent staff

Effective systems were not always in place to ensure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Specialist training for staff specific to their roles was provided. However, effective systems were not in place to ensure staff consistently completed all the required additional training for their roles. We found that an effective system was not in place to ensure midwives responsible for recovering women post anaesthesia were competent to carry out this role. At the time of our inspection, only 24 of the 42 midwives eligible for recovery training had completed this training and a list of competent midwives in recovery was not readily accessible to enable midwives in charge to allocate competent staff to the recovery role. This meant there was a risk that women would be recovered by staff who were not trained to do so. We escalated this during our inspection and the trust told us how they would address this to mitigate this risk. We found no evidence that harm had been caused as a result of this competency gap.

Additional training in fetal monitoring was provided to all registered staff, this included CTG training. The trust's CTG training target was 90%. Training data for September 2021 showed that 76% of midwives and 70% of consultants had completed this training. Training data for trainee doctors was much lower at 27% but this was because trainee doctors had recently rotated and their training was in progress. All staff had received a reminder to complete this training in order to improve compliance rates. Support staff also told us they were able to access specialist training for their role. This included attending breastfeeding workshops to enable them to offer practical and emotional support to women.

Staff participated in multidisciplinary training and utilised external resources including those produced by the Practical Obstetric Multi-Professional Training (PROMPT) charity. PROMPT is an evidence-based multi-professional obstetric

emergencies training package that has been developed for use in local maternity units. Staff we spoke to confirmed they participated in MDT training and that the service had adapted during the pandemic and moved to virtual PROMPT training. PROMPT compliance data from November 2021 showed that 75% of midwives and 57% of medical staff had completed this training. The trust had plans to achieve their 90% target compliance rate by March 2022.

Private social media platforms were also utilised to make training more accessible to staff. For example, a social media live video showing staff how to don and doff personal protective equipment had been shared that staff could replay at a time convenient to them.

Managers gave all new staff a full induction tailored to their role before they started work and staff were supernumerary in their areas until they became familiar with the service's environment and processes.

Newly qualified midwives undertook a preceptorship programme and competency assessment. They were supported throughout the programme and met regularly with their supervisor.

Managers supported staff to develop through yearly, constructive appraisals of their work. This ensured that staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. At the time of our inspection, 91% of medical staff, 67% of registered nursing staff and 81% of support staff had received an appraisal. Nursing and support staff appraisal rates were below the trust target of 90%, however plans were in place to increase appraisal rates and staff and managers had been contacted to remind them to engage in the appraisal process.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us team meetings had become more accessible as they had moved to virtual meetings.

Managers identified poor staff performance promptly and supported staff to improve. Examples were shared that demonstrated this.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed these meetings and saw that risks were appropriately discussed and information was shared in a manner that promoted continuity of care.

All the staff we spoke with spoke positively about the multidisciplinary working on the wards, within the wider hospital and in the community. We saw maternity staff worked effectively with other teams within the hospital. This included working with surgical teams and paediatricians.

Staff worked across health care disciplines and with other agencies when required to care for patients. Records showed that staff referred women to other agencies such as; safeguarding, social care and mental health services.

Maternity

Is the service well-led?

Good

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The senior leadership team within maternity were mostly new to post since our last inspection. Staff described this as refreshing and positive. The managers and leaders we spoke with displayed enthusiasm and drive to improve maternity services for the women, babies and staff.

Managers had the right skills to perform their roles effectively. Managers and senior staff told us that management level training was provided to ensure their leadership skills continued to be developed and improved.

Managers and senior leaders displayed the qualities required for effective leadership. This included being approachable and accessible. Staff told us and we saw that managers and senior leaders were visible in all the areas we visited. All the staff we spoke with told us they felt supported and valued by their managers.

Culture

Staff felt respected, supported and valued. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, staff had accepted the poor estates and facilities which meant concerns around this were not always escalated to improve patient care.

We saw there was an open culture as most staff spoke with the inspection team openly and honestly. Staff told us there was a no blame culture and they felt able to raise concerns with their managers and freedom to speak up guardians were accessible if required. However, we found there was a culture amongst staff and leaders of acceptance of the poor estates issues such as the broken blinds. This led to a culture of under reporting these concerns.

Joint meetings and training sessions were facilitated within this service and the service at the Pilgrim Hospital site. This promoted joint working and learning between the two maternity units at the trust.

Staff promoted equality and diversity within the service. Staff told us they cared for women from minority groups. Staff understood and used the trust's systems to ensure these women and their families were able to access appropriate care.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Senior leaders from maternity services attended monthly cross site Maternity and Neonatal Oversight Group (MNOG) meetings. The purpose of the MNOG was to have oversight of maternity and neonate services to monitor if these services were safe and in line with national safety and quality standards. The group discussed key topics such as; the maternity

and neonatal monthly safety assurance report and monitored the progress and effectiveness of the local maternity improvement plan. The maternity and neonatal quality dashboard which included incidents and other safety data was also scrutinised by senior leaders and external stakeholders in the MNOG meetings. Minutes of these meetings showed that the agreed terms of reference were followed, safety and quality concerns bought to the groups were appropriately acted upon and any improvement actions were appropriately followed up.

Stakeholder feedback was discussed at MNOG. This included stakeholders such as; NHS England and Improvement and patient groups.

The MNOG fed into the trust's Quality Governance Committee (QGC). Minutes of MNOG showed that areas of concern were escalated to the Quality Governance Committee and to ensure any identified risks were appropriately captured. The QCG then fed into the board to ensure they had a regular overview of quality, safety and performance relating to all services at the trust, including maternity. Minutes from trust board meetings evidenced this.

The maternity service had a non-executive director sponsor who was the services named maternity and neonatal safety champion. This sponsor attended the MNOG meetings on a regular basis.

Staff told us that mortality and morbidity reviews were regularly completed to review and learn from deaths, incidents of sepsis and other adverse incidents. However, records did not always evidence the discussion and outcomes of these meetings. The trust were aware of this and had a plan in place to address this. These reviews were not cross site meetings, therefore this was a missed opportunity to have cross site discussions and learning from deaths and other adverse events.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always ensure risks were identified, escalated and mitigated in a timely manner. The service had plans to cope with unexpected events.

The maternity dashboard audit scores from July to September 2021, had not been effective in addressing risks associated with the environment; the general environment for the maternity ward was consistently scored as 78% and RAG rated as red. This meant the equipment and facilities concerns we identified such as; unsafe door frames, broken bath panels and non-functioning blinds, whilst identified, had not been addressed in a timely manner.

The lack of action from the estates team to address reported issues had also not been effectively escalated to ensure reported issues were rectified in a timely manner. This included the broken toilet seat that had been reported in May 2021 that had not been fixed at the time of our inspection.

We found that when risks had been identified, they were appropriately managed. Identified organisational and patient safety risks were recorded on the service's risk register. Each risk was assigned a risk score and level based on its severity and review dates were set and met. For example, staff had identified that paper CTG readings faded over time which meant there was a risk of accurate records not being maintained. This had been recorded on the risk register and appropriate mitigation plans were in place while a long-term solution was agreed. Minutes of governance meetings evidenced that the risk register was discussed on a regular basis which showed there was senior management and board level oversight and management of risk.

Each area's top three risks were also shared to staff through the use of governance boards which meant staff were aware of the risks and the mitigation plans in place to address these risks.

Maternity

A monthly maternity and neonatal quality dashboard was produced. Items covered included national safety standard performance data, such as; 10 Steps to Safety performance data (a national maternity incentive scheme used to improve safety) and saving babies lives performance data (a nationally recognised care bundle aimed at reducing perinatal mortality). Other performance data was also included in this report, including; incidents, patient feedback, complaints and staffing training compliance. Senior leaders told us this provided key information to enable them to have effective oversight of quality and safety within the division.

Managers told us that staff performance issues were addressed in line with the trust's performance and disciplinary policies and procedures.

Medical care (including older people's care)

Good

Is the service safe?

Good

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training. The trusts target for mandatory training was 90%, the average completion across all of the courses for medical wards was 79%. During the Covid-19 pandemic, mandatory training and been paused and at the time of the inspection was in progress of being delivered to be back to the trusts target. The trust aimed to be back to 90% completion by the end of November 2021.

During the inspection, bank staff across the trust reported that they did not always feel supported with their mandatory training and with having time to complete it. This was raised with the trust and they provided us with assurance that they were looking into mandatory training for bank staff and putting processes in place to support this.

Medical staff received and kept up-to-date with their mandatory training. At the time of our inspection the completion rate for medical staff mandatory training across the medical wards was 66%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us that the online learning was easy to access and covered what they needed it to.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. Staff completed this training once every three years, the compliance rate for Mental Health awareness training at the time of our inspection was 90% and dementia awareness was 91%. At the time of our inspection the trust were in the process of starting training on learning disabilities and autism and hoped to have this started by December 2021.

Managers monitored mandatory training and alerted staff when they needed to update their training. The trust had reports that could be collated to show compliance with mandatory training at different levels and this was monitored through the trusts governance structures.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Staff completed safeguarding mandatory training with levels completed according to their roles. 82% of eligible staff across the wards had completed safeguarding adults level 1 training, 72% had completed level 2 training and 75% had completed level 3 training. 82% had completed level 1 safeguarding children training, 73% had completed level 2 safeguarding training and 71% completed level 3 training.

Medical care (including older people's care)

Medical staff received training specific for their role on how to recognise and report abuse. 60% of eligible staff across the wards had completed safeguarding adults level 1 training, 61% had completed level 2 training and 75% had completed level 3 training. 61% had completed level 1 safeguarding children training and 62% had completed level 2 safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff could describe caring for patients with protected characteristics and how to keep them safe.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could describe how they had worked with other organisations in the past to make sure that patients were protected from harm. Staff told us about how they had put measures in place to ensure patients were protected from harm and also had their individual wishes listened to.

The safeguarding team completed monthly safeguarding audits to assess the quality of safeguarding and DOLS referrals. In September 2021, three safeguarding referrals were classed as poor, eight as ok and five as good. Four DOLS referrals were classed as poor, ten as ok and 52 as good. This then helped the safeguarding team to decide where to focus their resources on to support and improving practice.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with also knew who to go to if they had any queries relating to safeguarding.

Staff followed safe procedures for children visiting the ward. At the time of the inspection visitors to ward areas were restricted in line with the trusts Covid-19 pandemic response plans.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. The trust has monthly infection prevention and control audits, these are divisional wide and compare scores both cross site and for individual wards. Dependent on the score the areas were either rated red (lowest scores), amber (some improvements required) or green (meeting targets). Based on the scores given action points were created.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). During the inspection we observed staff using PPE appropriately and wearing masks throughout our visit. There was also clear signage on the wards to show Covid-19 risk levels for different areas and where patients were being isolated due to infectious diseases or illnesses.

The trust also had daily bulletins which could be used to share key messages such as updates about Covid-19 and steps required to prevent the spread of infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Across the hospital it was the responsibility of the health care support workers to clean the bed areas once the patient had been moved. Staff told us that this could slow down the flow of patients into ward areas at different times. During our inspection we went to the Medical Emergency Assessment Unit (MEAU) and found five beds waiting to be cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called.

The design of the environment did not always follow national guidance. Some of the wards we visited were old and required refurbishment. The trust had plans in place regarding refurbishments and were working through the wards. The trust had recently carried out some refurbishment works on Coleby ward, Clayton ward, Lancaster ward and Medical Emergency Assessment Unit (MEAUB). However, staff did report that timescales could change and they weren't fully assured the improvements would be made.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys containing medicines and equipment required in an emergency were accessible on all wards we visited. They were safely secured with tamper proof seals. Most of resuscitation trolleys we looked at during our inspection were checked daily and weekly to ensure they were stocked, equipment was in working order and medicines were up to date. However, one ward which we visited, which had just been opened to receive patients, had a resuscitation trolley which had not been checked. This was not in line with the trust policy of checking wards before they were opened.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients. However, there was no telemetry available in the Medical Emergency Assessment Unit (MEAU) and to enable staff to safely monitor patients they would be required to sit in the patients bed area to monitor the screen. Staff working on the ward managed this risk by using the extra member of staff to complete these observations who would usually assist with admissions.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including sharps. Sharps bins seen were appropriately labelled and stored correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. The form was within the patient pathway document. Scores were completed correctly. When a high score had been calculated, indicating increased risk for the patient, they would be escalated for medical review.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. . The patient pathway document included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE).

Staff knew about and dealt with any specific risk issues. The trust had processes in place to ensure patients received specialist care when required. If patients scored more than five on their NEWS2 then they would be seen by the critical care outreach team and if they had a score of more than seven then they would receive an immediate response by the critical care outreach team.

Staff completed monthly VTE audits, in September 2021 the audit score was 97% for medical wards. This indicated staff were following the trusts policies correctly and reducing risks for patients.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

Staff shared key information to keep patients safe when handing over their care to others. Staff used a handover sheet to record key information when handing over care to other staff. If patient risk levels were high, nursing staff from the ward would accompany the patient to move to the new ward area.

Shift changes and handovers included all necessary key information to keep patients safe. Each area had a safety huddle twice a day. All staff on duty attended the huddle and were updated on all key information.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Each ward staffing establishment was reviewed at least twice yearly in order to ensure meeting safe staffing standards. During our inspection the wards we visited were staffed in line with these guidelines. The trust had recruited a large cohort of overseas nurses in order to increase substantive staffing numbers. The trust also had a bank of nurses in order to ensure staff familiar with trust policies and procedures were employed where possible. Ward staff were also offered overtime where possible. However, to maintain these establishments most wards were still required to use agency staff. The trust was working towards a reduction in agency spend with increased recruitment and talent management in order to ensure skills were used for the benefit of the local population.

Managers accurately calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants needed for each shift. Managers populated a staffing software which determined the level of acuity and dependency for patients. This calculation informed the nurse to patient ratio and skill mix as well as quantity of registrants on duty.

The ward manager could adjust staffing levels daily according to the needs of patients. Staffing was managed across the trust by daily staffing meetings and staff could be moved to help support areas with lower staffing/higher acuity. During the inspection staff described the anxiety and stress having to move wards caused them. We were also told about staff who had left or were in the process of leaving due to the number of times there were moved from their usual place of work to work on another ward.

The number of nurses and healthcare assistants matched the planned numbers.

The service had reducing vacancy rates. At September 2021 the hospital had a vacancy rate of 15.5% for nursing, nursing associates and health care support workers. The trust had worked hard over the last year to recruit staff onto the wards and had recruited a number of overseas nurses.

The service had an increasing turnover rate. At September 2021 the hospital had a turnover rate of 18.9% for nursing, nursing associates and health care support workers. Staff told us that this was due to the impact of Covid-19 on staff.

The service had a higher than average sickness rates. At September 2021 the hospital had a sickness rate of 7.8% for nursing, nursing associates and health care support workers. Most of this sickness could be attributed to the impact of the Covid-19 pandemic.

For the medical wards the Allied Health Professional vacancy rate was 17.7%, turnover rate was 15.8% and sickness 1.8% (September 2021).

The service had reducing rates of bank and agency nurses used on the wards.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. However, it was necessary to rely on the use of locum staff to do this. During August and September, the total number of shifts unable to be covered was 2239. Of these 49.5% were covered by agency, 3.9% were covered by care1 bank (a collaborative regional bank arrangement with other trusts) and 37.38% were covered by internal bank.

The medical staffing did not always match the planned number. In August and September 2021, 9.1% (205) of shifts were not filled. As part of the trusts risk management, core shifts within medicine will not be left unfilled, only those shifts deemed to be low risk to patient safety would be left unfilled. If a core shift was unable to be covered through the bank, or agency, alternative mitigations were applied to ensure the shift was covered including the use of acting down arrangements.

The service had reducing vacancy rates for medical staff. Lincoln County Hospital had a vacancy rate of 16.5% for medical staff across the wards in September 2021.

The service had low turnover rates for medical staff. Lincoln County Hospital had a turnover rate of 4.4% for medical staff across the wards in September 2021.

Sickness rates for medical staff were low. Lincoln County Hospital had a sickness rate of 2.3% for medical staff across the wards in September 2021.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. A locum member of medical staff who we spoke with told us they had an induction and a tour of the department when they started in post.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Staffing was a key area of focus with a range of reviews and controls in place.

The service always had a consultant on call during evenings and weekends. During the pandemic some wards had also utilised virtual consultant ward rounds to ensure effective patient care decisions were made.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, mostly stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Notes we looked at were easy to follow and consistently filled out. The trust had standard booklets and forms to fill out for patients notes which helped staff to ensure comprehensive records were kept.

When patients transferred to a new team, there were no delays in staff accessing their records. The trust had an electronic system on which staff recorded observations, key information and treatment plans. This was accessible on all wards and enabled staff to quickly identify areas of risk and treatment plans for patients on the ward. Paper nursing and medical notes were also transferred with patients when they moved wards.

Records were generally stored securely. On the wards we visisted notes were stored in lockable trolleys which were locked when not in use by staff. On some of the wards we visited these had been moved so they now were stored in the patient bays to ensure staff members were more visible when completing their notes. On one ward we visited there was a notes trolley that was left unlocked and was near to the entrance to the ward meaning anyone could walk in from the main hospital corridor and have access to the notes. This was raised with the ward manager who reminded staff the importance of ensuring the trolley was kept locked when not in use.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored securely.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Charts demonstrated medicines were prescribed and recorded appropriately.

Some of the wards we visited had dedicated pharmacist support. However, those that did not reported that there could be delays in getting charts reviewed.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Ward and medical staff spoke to patients about their medicines, occasionally a pharmacist would also speak to patients – usually related to medicines reconciliation activity.

Medicines were not always stored safely. We found tablet blisters mixed in a box (not the original containers) in two trolleys. The trolleys however were locked so the risk was that medicines would be incorrectly picked during drug rounds not that there could be unauthorised access to medicines.

Staff followed current national practice to check patients had the correct medicines. We heard that medicines reconciliation was completed by pharmacist and pharmacy technicians but not completed at weekends on the ward. When patients were admitted over a weekend their charts were prioritised for reconciliation when pharmacy team members arrived on the ward on Monday. We heard that, due to time constraints, not all charts were reviewed by pharmacy staff daily, but patients were prioritised for review based on complexity of treatment regime, discharge and admission dates.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. During the inspection we spoke with staff who were aware of the sedation policy and aware of previous incidents within the trust. All wards now had sedation logs and staff were aware of where these were stored and when to complete them.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Staff said they were encouraged to report incidents and near misses

The service had no never events on any wards. Managers shared learning with their staff about never events that happened elsewhere. There were quarterly trust wide learning to improve bulletins that were circulated to staff. These covered learning actions taken from serious incident investigations across the trust.

Staff reported serious incidents clearly and in line with trust policy. We reviewed the last three serious incident reports for the medicine wards at Lincoln. These were clearly written, thoroughly investigated and identified areas of good practice and areas for improvement.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence that changes had been made as a result of feedback. The trust had previously identified a number of serious incidents in relation to Diabetic ketoacidosis (DKA). This resulted in the diabetes ward not taking any new admissions with DKA and instead they would be cared for on the Medical Emergency Assessment Unit (MEAU). The ward then did work to train staff and recruit additional nurses and had plans to restart taking those patients once the work had been completed.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Medical care (including older people's care)

The NHS Safety Thermometer provided a 'temperature check' on harm that could be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for all patients. Following consultation, the national collection of data stopped in April 2020 with the proposed developed of replacement data collection and reporting then impacted by the COVID-19 pandemic.

Staff used the safety data to further improve services. Leaders reviewed their team's performance with regard to the trust quality assurance dashboard and areas for improvement were cascaded throughout staff teams. Operational performance data was collated and reviewed at the trust's divisional board meetings.

Is the service effective?

Good 

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff said guidance was easy to access, comprehensive and clear to follow. They showed us how they accessed the guidance.

We saw clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

There was a trust wide improving respiratory services programme which had started at the time of the inspection. The trust had recently completed a new respiratory unit at Lincoln Hospital. This met current best practice guidelines and standards and allowed staff to safely care for patients.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff working with people who were detained had support from the safeguarding team to ensure patients rights were protected. Patients also had access to advocates who were independent from the trust who they could speak to raise concerns or queries.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. During the inspection we observed staff offering a choice of meals for their lunch with different options available. During the inspection we spoke with patients who told us that they had plenty of choice and that the food was good.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed. Nutrition and fluid care plans were followed with fluid balances totalled and acted upon appropriately.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain scores were recorded in most patient notes. Staff used pictorial aids to assess the pain of patient who could not communicate verbally.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. Matrons working across the service checked staff assessed patients' pain with a validated pain tool and appropriately responded to patients' pain during their monthly audits.

Staff working in the trust described how the pain team used to be based in the hospital three days a week and were now based in the community. They described them as being less visible but still able to make a referral to them and have patients assessed when required.

Patient outcomes

Staff monitored the effectiveness of care and treatment. The trust performed poorly on a number of clinical audits.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff used the results to improve patients' outcomes. Staff completed a variety of clinical and environmental audits to provide assurance about local practice in their areas. The trust carried out monthly sepsis audits on all of the wards. These identified if there were any delays in treatment and possible reasons for this. Most wards had improved results from August to September 2021.

The service participated in relevant national clinical audits. The Trust were participating in 97% of all relevant national clinical audits and were in the process of registering for the inflammatory bowel disease audit which would make them 100% compliant.

As a result of the Covid-19 pandemic and the resulting ward reconfigurations, performance had declined on a number of national clinical audits including; the National Lung Cancer Audit 2020 and the Sentinel Stroke National Audit Programme 2019/21. The Healthcare Quality Improvement Partnership (HQIP) National Clinical Audit Benchmarking (NCAB) report for the data period 2018/19 was published in July 2020 and showed the trust to be performing generally 'as expected'.

Medical care (including older people's care)

The trust's percentage of patients on incomplete referral to treatment pathways that had waited less than 18 weeks was lower than the England average. Performance for completed non-admitted pathways was also lower than average. However, performance for completed admitted pathways was similar to the England average.

The service had a high risk of readmission. From October 2020 to September 2021 across all medical wards there was a 21.2% chance of readmission within 30 days. The risk of readmission was higher than expected for elective clinical haematology and gastroenterology at Lincoln County Hospital. However, this data could not be compared to other years as a result of the Covid-19 pandemic.

Managers shared and made sure staff understood information from the audits. The trust were committed to being involved in 100% of national audits in order to ensure improvements for patients. Information from audit was fed back to ward staff and learning embedded by use of a folder with recent SI's and learning and any changes of practice. Information was also cascaded through the huddles. Governance meeting minutes also provided information for ward staff.

The trust had its own internal accreditation scheme. This scheme had a clear process in place for monitoring quality in all clinical areas. Wards were RAG rated each month following completion of an audit undertaken by a matron. Once a ward had achieved the desired rating of green for consecutive months, accreditation status would be given.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Across the medical wards a number of overseas nurses had recently been recruited. They had a bespoke support package in place to ensure they were fully supported both in work and outside of work to help them to settle into their roles and encourage them to stay. They had competency's that they had to complete before they were signed off to complete certain tasks such as intravenous (IV) medication and also were supernumerary until they felt fully comfortable to look after patients independently.

Managers supported staff to develop through yearly, constructive appraisals of their work. Across the medical division there was an average appraisal completion rate of 93%. Across the medical division for non medical staff the average appraisal rate was 55%. The trust had a plan and targets they wanted to achieve to increase appraisal rates after they were paused due to the pandemic.

The clinical educators supported the learning and development needs of staff. Staff on the wards spoke highly of the clinical educators and how they supported them in their roles.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that they had completed extra training specific for their roles and that this was easy to access and helped them to develop.

Medical care (including older people's care)

Managers made sure staff received any specialist training for their role. Specialist teams provided regular bite size training to ward staff to maintain their specialist skills.

Managers identified poor staff performance promptly and supported staff to improve. This could be done through informal support on the ward or through formal processes dependent on the concerns identified.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

On the stroke ward, The National Institute for Health and Care Excellence (NICE) guidelines state that patients should be seen by physiotherapists and occupational therapists for a minimum of 45 minutes a day five days a week. The unit was meeting this target.

During the inspection we were told of different ward areas who had recruited band five pharmacy technicians into their establishment figures. Staff told us how valuable they were on the ward and how they had helped to improve patient care and standards on the ward with their expert knowledge.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The mental health liaison team was available for advice, and to support ward staff care for patients with mental health needs. During both days of the inspection we saw the mental health team working and assessing patients on the wards we visited.

Patients had their care pathway reviewed by relevant consultants

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff described how it could sometimes be difficult to get specialities to review patients at weekends and could be difficult to get MRI's completed at weekends.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. We saw posters and information leaflets throughout the service for patients and relatives to promote a healthy lifestyle.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff could refer patients to external organisations for specific support needs such as stopping smoking or drinking alcohol.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. On admission all patients had a capacity assessment document completed. If there were no concerns about a patient capacity a box would be ticked and no further action taken and if there were concerns a capacity assessment would be completed to help decide the required support for the patient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. During the inspection we observed staff asking for verbal consent before undertaking any care and treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were completed correctly.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act training was mandatory, at the time of our inspection 71% of staff had completed this training.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Monthly audits were completed which identified good practice and wards where improvement was required. These were discussed at a safeguarding oversight meeting and support plans agreed for wards requiring targeted training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were supported in making decisions in line with legislation and guidance by the safeguarding lead. The lead had a visible presence on the medical care wards from Monday to Friday to offer specialist support and advice to staff. Staff told us that if they required advice, they could easily access the safeguarding lead.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. There was an audit of the mental capacity act documentation completed across the sites. In July they looked at seven records. Four were found to have capacity assessments fully completed, and three not completed or not fully completed. Following this audit actions taken were to share the findings with the ward managers.

Medical care (including older people's care)

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw from the patient records we reviewed that all DoLS applications had been made in line with trust process. All staff had completed mental capacity assessments around the specific question of being able to give consent to remain in care and to care arrangements. Urgent and standard DoLS applications were made on appropriate paperwork and the dates were accurately documented.

Is the service caring?

Good 

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff told us how they spent time getting to know the patient as an individual to ensure that they were aware of their wishes and how best to support them.

Patients said staff treated them well and with kindness. Patients we spoke with told us that staff were all very kind and caring and 'couldn't do enough for them'.

Staff followed policy to keep patient care and treatment confidential. During the inspection we saw curtains being used to protect the privacy of patients when delivering any care, treatment or discussions.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. All staff we spoke with clearly understood patient needs.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. 77% of eligible staff working at Lincoln had received this training.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff explained how they would include patients loved ones in discussions about their care if this was the wish of the patient.

The hospital had a cancer care coordinator whose role was to assess and support the holistic needs of the patient.

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with generally reported that they felt involved in their care and decisions and that staff were approachable and felt able to ask any questions they had.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Some patients reported that the way that information was given to them was not always in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. On all of the wards we visited there was information on how patients and their families could give feedback on their care.

During the inspection we were told about how patients could feed into improvements they would like to be made on the wards and on one ward how they could add items onto a 'wish list' to be paid for by charitable money.

The trust used patient stories to share where care and treatment had met the expectations of patients and also where there were improvements to be made.

For August across the medical division 83% of patients surveyed would recommend the trust as a place to receive care.

Staff supported patients to make advanced decisions about their care. The trust had an end-of-life team who specialised in palliative and end of life care. This team supported both patients and staff to make advanced decisions about care.

Staff supported patients to make informed decisions about their care. Staff had access to specialist teams who supported patients. For example, cancer, diabetes, stroke and mental health specialist teams visited the wards regularly.

Patients gave positive feedback about the service.

Is the service responsive?

Good ↑

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services so they met the changing needs of the local population. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were all aware of the dementia liaison team and their contact details and reported a good collaboration with them.

Medical care (including older people's care)

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust had monthly reports on the number of mixed sex breaches and where they occurred across the trust. They also had policies in place on eliminating mixed sex accommodation breaches and steps for staff to take to reduce this. The main area that report mixed sex breaches was the medical emergency assessment unit (MEAU), this was due to patients being moved there quickly from the emergency department. The trust had put support in place to reduce the number of mixed sex breaches in the MEAU.

Facilities and premises were appropriate for the services being delivered. Waiting areas, clinical rooms and bays contained the required equipment according to internal policies and national regulations.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospital had a frailty team who worked closely with the emergency department and accepted patients into a health care of the older person ward, these patients were then fully assessed with the aim to have them discharged on the same day. This enables the patients to receive the care they require in an environment that is more suited to their needs and also creating space in the emergency department for new admissions. The plan moving forwards was for the area to be able to take patients and referrals direct from GPs and the ambulance service. This would mean that patients wouldn't have to attend the emergency department and would mean their care was handled by a more specialised team.

The service relieved pressure on other departments when they could treat patients in a day. The same day emergency care unit, located by the ED aimed to see patients who could be assessed/treated within the day and to avoid unnecessary admissions. There was a clear inclusion criteria that patients must meet in order to be eligible for care there. Whilst we were inspecting staff told us about plans to change the environment to allow for more patients to be treated safely.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff linked in with leads across the trust for support and guidance. They also worked closely with patients usual care delivery teams to ensure their needs were met.

Staff told us about how they would manage patients who were 16 or 17 and it was more appropriate for them to be cared for in the adult ward areas. They described linking in closely with the paediatric doctors to ensure the correct care and treatment was given. They also described how they would aim to treat them in a side room and facilitate parents to stay if required.

Wards were designed to meet the needs of patients living with dementia. A number of the wards had recently undergone refurbishments and had improved their accessibility for people living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The referral system was through the online electronic record used throughout the hospital, so it was quick and easy to refer patients for speciality referrals and beds.

Managers and staff worked to make sure patients did not stay longer than they needed to. On the stroke unit there was a discharge coordinator role being trialled three days a week. At the time of our inspection they were completing an audit to decide whether to increase this to five days a week. Staff on the ward told us that on the days that the discharge coordinator was not available that flow on the ward was affected.

The service moved patients only when there was a clear medical reason or in their best interest. There were 1295 patients moved across the medical wards In September 2021 from the ward they were admitted to to another ward.

The trust used the discharge lounge for a place for patients to be cared for instead of waiting in the emergency department while they were awaiting an assertive in-reach assessment (frailty assessment). This resulted in patients, at times, being in the discharge lounge for long periods of time. In July 2021 there were 33 patients who were in the discharge lounge over 12 hours, August 39 patients and September 37 patients. The patients were moved to the discharge lounge overnight then were seen by the team in the morning before usually being discharged out that afternoon.

Managers and staff worked to make sure that they started discharge planning as early as possible. The average length of stay across all medical specialties was longer than expected for both elective specialties at Lincoln County Hospital. Average length of stay across all of the wards was 3.9 days with the longest average length of stay on the stroke unit (11.2 days) and Scampton ward (9.7 days). The average length of stay for the MEAU was 2.6 days from the last year. With 65 patients staying for eight days or longer.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff working on the wards aimed to plan discharge when patients were admitted to ensure the process was as short as possible.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The trust worked with the local system to make them aware of delays relating to discharge and to facilitate discharges.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Occupancy across the wards was 99%.

Medical care (including older people's care)

Managers worked to minimise the number of medical patients on non-medical wards. Where medical patients were not on the speciality wards they required there were clear processes for medical review to continue to ensure their care and treatment was not impacted upon.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Across the medical wards there were 77 complaints received in the last year. The most common themes were communication, delay in treatment or diagnosis and being discharged too soon.

The service clearly displayed information about how to raise a concern in patient areas. There were patient feedback leaflets on all the wards. The trust responded to complaints within set timescales and followed their internal policies as well as the national guidance. Staff told us how the duty of candour was met, including recording of the process and the involvement of patients and families.

Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process, and give examples of when a complaint was received, how it was handled and the outcome.

Managers investigated complaints and identified themes. The average time taken to respond to complaints was 53 days.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed one patient complaint in relation to medicine at Lincoln County which addressed all points raised by the complainant, gave detailed responses and were written in a sympathetic manner.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Serious incidents which were at the origin of complaints were discussed with staff and escalated.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good ↑

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Medical care (including older people's care)

Medicine had its own division within the trusts management structure. This division included all of the medical wards and the urgent and emergency department. The leaders worked in a multi-professional triumvirate which included a manager, doctor and nurse. Care group senior managers and clinical leads were seen regularly in ward areas. Staff felt able to raise concerns and were confident their concerns would be listened to and acted upon. Ward staff said they were well supported by their ward managers and matrons.

We observed good leadership skills in all ward areas. Leaders were seen giving clear directions and support to junior colleagues.

Staff were encouraged and supported to develop their skills and take on more senior roles. There were development pathways to support staff to progress.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had five key values:

- **Patient-centered-** Putting patients at the heart of our care.
- **Safety-** Ensuring patients and staff are free from harm.
- **Excellence-** Supporting innovation, improvement and learning.
- **Compassion-** Caring for patients and loved ones.
- **Respect-** Treating our patients and each other positively.

During the inspection we observed staff to be displaying these behaviours in the care and treatment they delivered.

The trusts vision was to be outstanding and was led by the trusts board. The division's vision mirrored that of the trust.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt valued, supported and spoke highly of their jobs. Staff said there was good teamwork and peer support. Staff spoke enthusiastically about their jobs. Most staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients.

Staff were proud to work for the hospital; they were enthusiastic about the care and services they provided for patients. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work.

On the wards we saw multidisciplinary working which involved patients, relatives, and the clinical team working together to achieve good outcomes for patients.

Medical care (including older people's care)

Patients acknowledged a positive and caring ethos and were happy with their care.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear governance structures within the trust with good representation from all disciplines. Governance group meetings directly fed into the trust board governance meetings.

There was a clear governance structure within the medicine group. Monthly meetings took place at all levels to discuss key risk and performance issues. Meeting minutes showed them to run to a set agenda and clearly recorded.

The medicine division also had monthly dashboards which covered data from across the wards and was collated into an overall performance report for the division. This highlighted areas of good practice and areas where improvements could be made.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Risks were recorded at ward division and trust level. The top three risks identified were the safe management of emergency demand, timely provision of Non-Invasive Ventilation (NIV) and capacity to manage emergency demand. These all had control measures in place, identified weaknesses/gaps in controls, planned actions and recorded progress. Leaders at all levels could clearly describe the risks in their area of work and the mitigation in place to reduce the risks. Monitoring of risks and actions were allocated to named staff who recorded regular updates with the mitigations to reduce the risk.

Throughout the medicine division, clinical and non-clinical managers worked well together to identify risks and make improvements. Matrons and ward managers had a good understanding of the issues within their clinical areas.

During the inspection there was a fire alarm when we were on one of the wards. Staff handled this well and carried out their process to ensure risks to patients were kept to a minimum. There were fire risk assessments completed for all wards and these contained information on how to improve fire safety on the wards.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Staff were aware of how to use and store confidential information.

Each area we visited had several computer terminals and computers on wheels to allow staff to access electronic patient records and test results. All staff had individual log on passwords and all terminals were locked when not in use.

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust used the friends and family test to gather the views of people using the service. They also gathered the views of patients and their loved ones through complaint and compliments. All of this information was gathered into a monthly report which detailed any actions and learning.

The trust also held patient panel workshops where members of the public were invited to discuss a variety of topics such as changes to services. These were a useful way for project leaders to be able to gather the views of people who would be using the services they were developing.

In 2019 United Lincolnshire Hospitals NHS Trust (ULHT) had become the first NHS trust in the country to be formally accredited by the 'Academy of FAB NHS Stuff'. The trust now had FAB Experience Champions identified on medical wards who acted as local leads for patient experience. Some of this work was new but aimed to engage with patients, families and their carers to improve care. For example, new monthly FAB Champions feedback on activities and patient panel discussions covered all aspects of care. This information all fed into the Medicine Division Patient Experience assurance report which provided an overview of themes and actions.

When the trust developed or reviewed services they complete a full equality impact assessment. They also had a system community database which allowed staff to engage with different groups to gather diverse views on services.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Following the last inspection, the trust had taken action to address the issues found across the service.

The trust had monthly medicine division confirm or challenge reports. These explored different measures across the trust and dependent on risk level identified drivers for change or metrics to continue to monitor. Each month these were updated dependent on risk levels and actions completed to improve the services across the trust. Areas for improvement including reducing medication errors causing moderate or severe harm and reducing agency spend for the year compared with the previous year.

During the inspection we were told about how the clinical engineering department had used a 3D printer to make a copy of an ultrasound probe to help a patient who was on the autistic spectrum to desensitise themselves prior to treatment. The idea was to provide the patient with an opportunity to get comfortable with the ultrasound probe to be used during procedure and prevent any undue stress or rejection of procedure. The probe was painted to replicate the original and a skin safe silicone was used on the tip of the probe that comes into contact with the skin during procedure.

Medical care (including older people's care)

The trust took part in a 100 day challenge with the community service to allow a smoother and more rapid (where appropriate) transition from hospital to home/community for individuals who had suffered a stroke and to allow people to be managed and to manage confidently in the community. As a result of this the team awarded a Chief Allied Health Professional Office (CAHPO) Award in October 2021 for Innovation and Delivery of Systems in relation to the 100-day challenge and all the progress they had made this year. This was one of 7 awards given out in England.

Services for children and young people

Good ↑

Is the service safe?

Good ↑

Mandatory training

Not all staff were up to date with mandatory training.

Not all nursing staff were up to date with their mandatory training. Data from the trust as of October 2021 showed training compliance ranged from 65.3% for resuscitation training to 96% for equality, diversity and human rights training (EDHR). This was against a trust target of 95%. Only one out of thirteen core modules showed the trust target had been met (EDHR). This was, in part, due to the pandemic. We found no evidence of harm to patients as a result of the mandatory training levels.

Data from the trust showed 54% of nursing staff were trained in European paediatric advanced life support (EPALS) against a target of 100%. Whilst the target was not met at the time of our inspection, staffing was arranged to ensure at least one EPALS trained nurse on shift at all times. The trust planned to increase training compliance to 76% by December 2021.

Band four staff (staff who were experienced in working with children but were not registered nurses such as nursery nurses and nurse associates) were trained in paediatric immediate life support (PILS).

Managers had secured funding for senior nurses to undertake advanced paediatric life support training (APLS) and were waiting for spaces to become available on training courses, particularly for Safari ward (day patient ward) as the paediatric assessment unit was located there.

Managers monitored mandatory training and alerted staff when they needed to update their training. Clinical educators focussed on supporting staff to become compliant with mandatory and specialist training for their role.

Medical staff were not all up to date with their mandatory training. Data from the trust from October 2021 showed training compliance ranged from 70.6% for staff charter training to 100% for moving and handling. This was against a trust target of 95%. Only one out of thirteen core modules showed the trust target had been met, however two further modules (EDHR and Health and Safety) showed just under 95% compliance. This was, in part, due to the pandemic. We found no evidence of harm to patients as a result of the mandatory training levels.

Data from the trust showed 67% of medical staff were trained in European paediatric advanced life support (EPALS) against a target of 100%.

Data from the trust showed 33% of medical staff were trained in advanced paediatric life support (APLS) against a target of 100%.

The trust reported difficulties in booking onto APLS courses due to Covid-19. Extensions had been granted to some medical staff due to this.

Services for children and young people

The mandatory training was comprehensive and met the needs of children, young people and staff. The modules staff completed were appropriate to the paediatric environment.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, although not all staff were up to date.

Nursing staff received training specific for their role on how to recognise and report abuse. However, some staff were not up to date with this. Staff compliance with safeguarding training varied. The trust target for safeguarding training over level one was 90%. Eighty four percent of staff eligible for level two safeguarding training for both adults and children had completed this training. All staff eligible for level three training in safeguarding adults had achieved this, and 82.7% of staff were compliant with level three safeguarding children training.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff were 76.5% compliant with training for safeguarding children and adults' level two. Medical staff did not complete level three safeguarding adults training routinely. They were 76.5% compliant with level three safeguarding children training. This was below the trust target of 90% for these modules.

The trust monitored training compliance; and set actions to achieve improved compliance rates.

The levels of safeguarding training undertaken by staff was appropriate as per the 'Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff' (2018) and the 'Intercollegiate document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' (2019).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could describe the types of abuse patients could experience. Staff were knowledgeable of the provider's safeguarding policy and described trust wide safeguarding staff they could approach for guidance and advice.

Staff knew the procedures if a child and their parent or carer did not attend an outpatient appointment. It was the medical staff responsibility to note this and to contact the person with parental responsibility.

Staff could access a division wide safeguarding supervision meeting via videoconference. This was run by the divisional safeguarding leads.

Staff followed safe procedures for children visiting the wards. Staff controlled entry to the wards via a buzzer system which allowed them to view and speak with anyone attempting to gain entry. People leaving the ward had to ask for staff to unlock the doors electronically.

We observed staff act as a chaperone for patients in outpatients.

Staff received training on preventing child abductions. This did not include scenario training at the time of our inspection.

Services for children and young people

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The housekeeping team knew what their daily duties included and kept a cleaning schedule. Staff cleaned bed spaces promptly when there were vacated.

All areas we visited had disposable curtains which were dated to show when they were last changed. All staff we spoke with were aware of when to change curtains more frequently.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used stickers to indicate when equipment had been last cleaned. All stickers we checked were recent, indicating these were used regularly.

Hazardous cleaning products were locked away.

Staff followed infection control principles including the use of personal protective equipment (PPE). Patients with infections or at risk of harm from infections were clearly identified and supported in side-rooms. Assessments indicated the level of infection risks associated with each patient and there was clear guidance about how to prevent the spread of infection and what PPE was to be used.

When possible, patients were tested for covid-19 prior to admission and there were procedures in place to test unplanned admissions upon arrival. Patients requiring planned surgery were tested three days before admission to the ward. There was a dedicated covid information board for staff, patients and visitors explaining how to identify symptoms and prevent its spread. There was a dedicated infection, prevention and control lead to educate staff and visitors and promote good infection control practices.

All people visiting the ward had access to regular handwashing facilities and hand sanitising gel. There were handwashing prompts and instructions at the ward entrance and sinks. Additional hand sanitizing gel was available in staff areas and at bedsides.

Staff used PPE when caring for patients and consistently washed hands before and after each patient contact.

Data from hand hygiene audits demonstrated a high level of compliance for the months of July to September 2021 on both Safari and Rainforest wards.

Cleaning records did not always demonstrate that all areas were cleaned regularly. For example, on Safari ward we found that the parents room cleaning checklist had not been completed the week of our inspection, 4 October to 7 October 2021. On the neonatal unit, we saw the cleaning log for high and low clinical areas was not completed for the 6 and 7 October 2021.

Cleaning audits for Safari ward showed between 94 and 98% compliance from November 2020 to September 2021. For Rainforest ward, compliance was worse; from 83% to 91% for the same time period. However, we did not see any incidents as a result of this; and the wards were visibly clean during our inspection.

Services for children and young people

Environment and equipment

The design, and use of facilities, premises and equipment kept people safe. However, the maintenance of the environment and equipment was not always prompt. Staff were trained to use equipment. Staff managed clinical waste well. Not all weekly fire checks were completed in line with risk assessment recommendations.

The design of the environment followed national guidance. The service had arrangements in place to ensure children and young people wards and clinics were secure. The main entrance to the neonatal unit, Safari ward, Rainforest ward and the children and young people outpatient's clinic could only be opened by a dedicated key card. Staff also had to electronically open doors for anyone without a swipe card to leave the ward. We saw staff use an intercom to check the identity and validity of people requesting access to wards. Fire doors were alarmed so patients were unable to leave without staff being alerted. Non patient rooms and areas within the ward had dedicated key code locks to prevent unauthorised access to items which could be harmful or confidential.

Doors and fire exits were kept clear however corridors on the Rainforest ward were cluttered with equipment, PPE and linen trolleys. We saw several pieces of equipment stored on the corridors awaiting disposal or repair. Some of these items had been left for two months. Several members of staff told us that faulty equipment was not consistently disposed of promptly. This presented potential obstructions and trip hazards. On one occasion we observed a patient's feed line get caught on a piece of equipment being stored on a corridor. We raised this with staff on the ward and found this particular piece of equipment was removed the next day. However, we saw a new piece of faulty equipment had been added to the area.

Fixtures were generally well maintained; however, we saw signs of wear to the floor at the Rainforest ward entrance and to some surfaces in bathrooms and toilets on the same ward. Worn flooring could present a trip hazard and surfaces no longer impervious to spills could support the spread of infection.

Staff allocated patients with higher acuity (more serious illnesses) to beds nearest the nurses' station. Therefore, staff could easily observe such patients and action taken promptly if required.

We saw toilets and bathrooms had been fitted with safer locks to enable staff to access the bathroom if necessary, and to prevent ligatures. However, bathroom facilities did have other ligature points within such as grab handles and bars. The trust provided an environmental ligature risk assessment however this was from October 2018 for both Rainforest and Safari wards. The audits stated these should be re-completed twice per year. Therefore, this audit was out of date and may not have reflected risk accurately. Following our inspection the trust provided an up to date environmental ligature risk assessment.

Children, young people and their families could reach call bells and staff responded quickly when called. Parents told us they could access staff quickly when required.

Staff carried out daily safety checks of specialist equipment. Maintenance staff completed regular safety checks of electrical equipment. We saw two contractors attend the ward to complete an annual safety check of a hoist.

The service had suitable equipment and facilities to meet the needs of children and young people's families. Staff had access to specialist paediatric emergency equipment in all areas we checked. A paediatric resuscitation trolley was available on all inpatient and outpatient areas, including theatres. This was checked daily, weekly and where necessary monthly. All trolleys were secured with cable ties; therefore, easily accessible in an emergency. We saw all planned equipment, medication and guidance was present and in date with one exception. The one exception was in the

children and young people outpatient clinic (clinic five) whereby one laryngoscope blade (a device to open airways) was out of date as of August 2021. Staff in the department were aware of this, and it had clearly been escalated to the trust wide resuscitation team who had also recognised this as part of a recent audit. A spare was available, and all staff knew to use the in-date version which was highlighted.

Staff had access to emergency 'grab' boxes which had been stocked by the hospital resuscitation team. This contained lifesaving medication and equipment suitable for children.

There were dedicated fridges for storing expressed milk. These were locked and secure.

Staff disposed of clinical waste safely. Clinical waste was stored separately in a dedicated locked room. We checked a number of sharps boxes across all areas we visited. All were dated and signed by staff so they could be easily traced if necessary. However, we did notice some sharps boxes in clinical rooms had the slide top open leaving a space large enough for a child to put their hand inside. However, it should be noted that children and young people would never be alone in these clinical rooms.

We observed cleaning products to be accessible on Safari ward; staff stored these in the sluice room in a lockable cupboard. The sluice room was not routinely locked which is acceptable. During our inspection we found the cupboard open and unlocked. We raised this with staff at the time who immediately rectified this.

We saw on Safari ward that the last recorded weekly fire check was June 2020. The most recent fire risk assessment dated April 2020 highlighted routine checks were not being completed and recommended this be done. We requested evidence that more recent weekly fire checks had been undertaken. Following our inspection, the trust provided evidence to show the fire risk assessment had been completed in November 2021. In addition, the trust stated, during the pandemic and in response to the increased risk of fire in some ward areas relating to an increased use of oxygen, fire risk assessments were prioritised to those wards that were high risk. Safari was not identified as an area with higher levels of risk hence the delay in the fire risk assessment being undertaken.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff used the Paediatric Early Warning Score (PEWS) system or the neonatal early warning scoring system (NEOWS) to record children and young peoples' vital signs and identify deterioration in these. The trust used electronic boards in inpatient areas so that staff could quickly see where patients were located, who the allocated nurse was for each patient and what their latest PEWS or NEOWS score was. The boards also showed where staff were overdue with re-assessing patients' vital signs. During our inspection we saw one occasion where a patient's observations were not taken within the required time frame. We escalated this to senior nurses who immediately addressed this.

Staff knew about and dealt with any specific risk issues. Staff knew how to identify if a patient was at risk of sepsis. If a patient scored five or more on their PEWS, staff were prompted to complete a sepsis screen. We check a sample of patient records where they had scored five or more and found that the screen had been initiated appropriately in every case.

Staff were supported to become competent with recognising a deteriorating child and identifying and escalating sepsis. Staff completed a specific competency booklet on sepsis and were required to complete e-learning.

The clinical educators supported new starters by delivering a sepsis session which showed how to recognise signs of sepsis, how to complete the trust paperwork and how to escalate concerns. Until new starters completed this assessment, they were required to escalate all patients with sepsis indicators to the nurse in charge.

Staff completed risk assessments for each child and young person on admission using a recognised tool, and reviewed this regularly, including after any incident. Staff completed risk assessments for skin integrity, nutrition and falls. Managers monitored the quality of assessments regularly through audit.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a child or young person's mental health. Staff could access the internal mental health team who could attend to speak with patients at any time of the day or night. Staff had access to the local mental health trust and the child and adolescent mental health service (CAMHS) during day shifts. Staff from CAMHS were starting to routinely work on Rainforest ward to support staff.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. Nurses had a risk assessment tool to assess patients who were at risk of suicide, self-harm or absconsion. This identified what level of staff monitoring was required to keep the patient safe from harm. Where necessary patients were allocated staff to provide continuous supervision. Staff told us that where 1-1 continuous supervision was required, this was always covered, even if other staff had to undertake additional duties to cover.

Staff from the community-based child and adolescent mental health service (CAMHS) attended the ward to support patients with mental health conditions who were assessed as requiring one to one observation due to a high risk of suicide or self-harm. CAMHS provided this additional support during day shifts.

Patients at risk of suicide, self-harm or absconsion were usually located in the patient bay nearest to the nurses' station to provide extra monitoring.

Staff did not use chemical restraint (such as sedatives) to restrain children and young people. Physical restraint was undertaken by trained CAMHS staff where possible. Staff on the ward could call security if necessary. Data from the trust showed that a new policy regarding restraint training was being written at the time of our inspection due to previous training not meeting the needs of staff and patients. At the time of our inspection, three paediatric staff members were trained in level three clinical holding. There were no dates at this time planned for more staff to be trained but the trust were reviewing training provision. The trust told us one patient had been physically restrained in the 12 months prior to inspection.

Shift changes and handovers included all necessary key information to keep children and young people safe.

Nurse staffing

The service had some staffing vacancies. However, shifts were covered to ensure there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Services for children and young people

The service did not always have enough nursing and support staff to keep children and young people safe. The service was not fully recruited for nursing positions. However, on the days of our inspection the numbers of staff on shift matched the planned numbers to keep patients safe. The service made use of regular agency staff to support the safe staffing of the ward.

The number of nurses and healthcare assistants matched planned numbers.

The trust sent nurse staffing data for July to September 2021; on Rainforest ward for July 2021; day shift staffing rates for registered nurses (RN) was recorded at 144% and unregistered staff at 100%. Night shift staffing rates for registered nurses (RN) was recorded at 185% and unregistered staff at 100%.

Staffing rates greater than 100% were as a result of a temporary uplift to the template in response to the need for further forward planning for the anticipated increase in admissions of severely ill, very young children with the respiratory syncytial virus (RSV).

One member of staff told us that staff occasionally were moved from the ward to support children in the emergency department. This meant there was a risk that there would not be enough staff to meet the needs of patients on the ward. Similarly, staff told us that they could be moved from one area of the children and young people service to a different area to cover shortfalls. However, staff told us the staffing coverage was kept safe despite moves.

Staffing within the neonatal unit met the British Association of Perinatal Medicine (BAPM) standards.

Clinical nurse educators and ward managers worked clinically as required to support sickness or other absences during the week. Matrons could also work clinically if required.

Where nurse numbers were low; nurses could be supported by having a higher rate of unregistered staff such as nursery nurses. Nursery nurses had specific paediatric competencies and were able to work under a registered nurse's supervision.

All nurses had the skills and qualifications to keep patients safe. Where nurses had not trained specifically as a paediatric nurse; they had undertaken competency training to enable them to work safely.

Within theatres, there were enough suitably trained nurses and operating department practitioners (ODPs) to support and recover children during and after operations.

In addition to nurses, the service employed nursery nurses, nurse associates and trainee nurse associates. Nursery nurses were band four, and not registered nurses. However, they were experienced in working with children and supported the nurses by completing work such as admission paperwork, taking patient observations and general patient care. Nurse associates were also band four and had received training to achieve registration with the Nursing and Midwifery Council (NMC). They were also able to support nurses by completing a range of duties. The trust were supporting some nursery nurses to become either nurse associates or paediatric nurses. Health care assistants worked in some areas such as on wards and in the children's' outpatient service. They worked at band two and supported nursing staff. Some health care assistants had gained competencies in a range of tasks including taking blood and undertaking patient observations.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. Managers ensured that the skill mix of nurses working supported the needs of the patients, for example by having a maximum of one adult only trained nurse on shift at one time.

The ward manager could adjust staffing levels daily according to the needs of children and young people. If necessary, staff could be sent from one site to another to support fluctuating needs of different wards. The trust funded taxis for this purpose due to the distance between sites.

The service had high vacancy rates. The trust target for vacancy rates was less than 5%. In July 2021 the vacancy rate was 10.2%. In August 2021 it was 11.1% and in September 2021 it was 10.2%.

The service had actively recruited paediatric nurses to some of the vacancies and was awaiting three nurses to commence employment at the time of our inspection.

The service had increasing turnover rates. July and August 2021 data showed 10% turnover rates; whereas in September 2021, the turnover rate was 12%. The trust target for turnover rates was 12% or less.

The service had low sickness rates against the trust target of 4.5% or less. Data showed sickness rated were low.

The service had high rates of bank and agency nurses. Staff told us that they were usually supported by the same agency staff when necessary to ensure there were enough staff to meet patients' needs and considered them, 'part of the team'. Agency staff were block booked in advance. Some agency staff had been regularly working on the ward for a number of years.

Managers monitored nurse staffing and agency usage as part of the risk register.

Managers made sure all bank and agency staff had a full induction and understood the service. The clinical educator delivered a paediatric induction for new starters and bank or agency staff.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. However, medical staff were often called to attend ED out of hours. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep children and young people safe. The medical staff matched the planned number during our inspection. However, medical staff were requested to attend the paediatric area within the Emergency Department out of hours to support urgent cases which impacted upon the ward coverage. During our inspection, we found occasions where children had not been seen within the recommended timescales. We explored this with managers and medical staff who told us this was due to stretched staffing, particularly during busy periods. Staff told us that at times of peak activity, children were risk assessed to identify who needed to have a medical review most urgently which meant some lower risk patients did wait longer for their initial medical reviews.

The service always had a consultant on call during evenings and weekends. Consultant cover was in line with the Royal College of Paediatrics and Child Health (RCPCH). On call consultants were available within 30 minutes out of hours.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Medical staff we spoke with said any gaps in cover were managed inter-departmentally by a doctor moving to the area of greatest need. Despite medical staff sometimes being short, medical staff told us patients were kept safe.

The service had recently implemented a second specialist registrar (SpR) to work night shifts, although they were not formally on the rota. Staff told us this had made a significant difference to the workload.

The service had high overall vacancy rates for medical staff. As of September 2021, the vacancy rate was 16.8% against the trust target of 5%.

The service had high turnover rates for medical staff. As of September 2021, the turnover rate was 18.8% against a trust target of 12% or less.

Sickness rates for medical staff were low. As of September 2021, sickness rates were 0.6% against a trust target of 4.5% or less.

The service had high rates of locum staff. This was to provide additional medical support and cover over the planned establishment. Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. Data from the trust demonstrated locums received a thorough induction.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Nursing notes were contemporaneous and detailed capturing description of nursing interventions. We saw evidence of medical reviews. Staff signed and dated their entries.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Patient records were mostly paper based; staff would take the records to where they needed to be located as necessary. Some patient records were in electronic form such as clinical observations. These could be accessed by logging into a trust computer.

Records were stored securely when not in use. Staff kept records for patients in the hospital in lockable cabinets near to nurse stations. However, we did see two occasions where patient records were accessible to unauthorised people. See well led ‘information management’ for more details.

Monthly documentation audits showed 94% compliance on Rainforest ward and 99% compliance on Safari ward for August 2021 against a target of 90%. This was an improvement on July 2021 which showed 89% compliance for Rainforest ward and 91% on Safari ward.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not always follow these.

Services for children and young people

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. We saw that managers had identified a theme of medicine errors as reported by staff including omitted medicines.

Pharmacists completed medicine reconciliation audits and omitted medicine audits trust wide; however, for July and August 2021, neither of the paediatric wards were included in the audit sent by the trust. Paediatric areas were included in an annual audit of fridge temperatures.

Matrons completed a monthly audit which included medicines management. From April to August 2021, Rainforest ward showed 100% compliance with most measures where data was submitted. The measure of recording patient allergy status in May 2021 showed 78% of records checked were compliant. For July and August 2021, staff were 60% compliant with the measure: self-administration forms are signed and in patients notes where applicable'.

Safari ward showed an overall similarly good level of compliance. An area for improvement was found in July 2021; staff were 70% compliant with the measure: self-administration forms were signed and in patients notes where applicable'.

Both controlled drug storage and missed dose audits demonstrated a high level of staff compliance April to August 2021 across both paediatric wards.

Staff on Safari ward used patient group directions (PGDs) for three medicines. PGDs are written instructions to help nurses supply or administer medicines to patients, usually in planned circumstances. We asked to see the PGDs which allowed the nurses to give these medicines however we were told these were not available as they were being re-written. Therefore, at the time of inspection there was no evidence that the nurses were working legally within the PGD framework.

Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. We checked medicine storage and prescriptions on both patient wards, the neonatal unit and within theatres. All medicines were stored correctly and securely. Temperature checks were undertaken as per the trust policy except for theatres where the ambient room temperature was not recorded. Paediatric services were included in an annual fridge temperature monitoring audit dated 2020/2021. This demonstrated that room temperature checks were not consistently completed including in paediatric theatre areas.

Controlled drugs were managed safely during our inspection. However, pharmacists completed quarterly audits which showed poor compliance with the family health directorate, under which children and young people service sits.

We saw two opened vials of medicines on top of the medicines waste bin. We raised this with a senior nurse who immediately disposed of these.

Medicines nearing expiry were clearly labelled and there was a process for returning these to pharmacy for destruction.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines. A pharmacist attended each day to review the two children's' wards and the neonatal unit. They checked prescriptions and undertook audits. Pharmacy assistants attended to check stock levels.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff did not use chemical restraint on paediatric patients.

Services for children and young people

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents, serious incidents and near misses in line with trust policy. Staff gave us examples of incidents they had identified and reported. Most staff reported incidents directly using the trust electronic reporting system. Junior and administration staff reported incidents by alerting the nurse in charge who would report the incident on their behalf.

The service had no never events on any wards. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from serious incidents was displayed on a clinical governance board in the matron's office.

Managers shared learning and themes from reported incidents. For example, the sepsis officer identified areas of improvement for ward staff. This was shared, and where necessary individual staff were supported to improve their performance.

Managers produced a quarterly 'learning to improve' bulletin which including learning from serious incidents, complaints and patient experiences.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. The duty of candour is a legal requirement; every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

Managers highlighted the importance of the duty of candour in quarterly 'learning to improve' bulletins.

There was evidence that changes had been made as a result of feedback. Following a serious incident whereby medical staff did not respond to nurse escalation of a deteriorating patient, changes had been made. Emphasis was placed on all staff developing their competency in managing deteriorating patients. Staff we spoke with told us they felt confident to professionally challenge colleagues where necessary. We saw managers actively encouraged to escalate concerns to more senior colleagues including registrars and consultants if they felt junior medical staff were not responding appropriately.

Managers investigated incidents thoroughly. We saw completed investigation reports, action plans and evidence of the learning being shared as above.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

Services for children and young people

The NHS Safety Thermometer provided a 'temperature check' on harm that could be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for all patients. Following consultation, the national collection of data stopped in April 2020 with the proposed development of replacement data collection and reporting then impacted by the COVID-19 pandemic.

However, managers collected performance data and monitored the results to improve safety. This data was displayed on wards for children, young people and their families to see. However, on Rainforest ward this was out of date at the time of our inspection. We raised this with staff who said they would update it.

Staff had access to up to date data which was displayed in the matron's office.

Staff used the safety performance data to further improve services. Managers undertook regular audits which highlighted areas for improvement to drive performance and ensure patient safety.

Is the service effective?

Good ↑

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers reviewed and updated policies and clinical guidelines as part of monthly governance meetings; such as relevant guidelines from National Institute for Health and Care Excellence (NICE).

The Royal College of Paediatrics and Child Health (RCPCH) sets out standards for acute general paediatric services. These include having a consultant paediatrician readily available within peak activity time periods and all children who are admitted to a paediatric department with an acute medical problem are seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission and a consultant paediatrician within 14 hours of admission. During our inspection, we found occasions where children had not been seen within the recommended timescales.

We requested audit data for time taken for medical reviews as per the above standards. The trust reported they do not routinely collect this data or audit these standards. However, an overall annual audit of the standards was completed in November 2020. This showed lesser compliance to the standards highlighted above in line with our findings on inspection; however found good compliance to other standards such as 'the general paediatric training rotas are made up of at least ten whole time equivalent posts' and 'specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians'.

The Bliss Baby Charter is a UK framework for neonatal units to promote best practice and a high quality of family centred care. There are seven principles that neonatal units are encouraged to work towards and undertake audits to self-assess compliance.

During our inspection, we saw the neonatal unit complied with aspects of the principles. There was a dedicated room for mothers to breastfeed their children or to express milk in neonates, with support for cot side expressing as per best practice guidance. However, on both wards, mothers were required to express at the bedside on the wards and in neonates. Although privacy curtains were in place, this may not have been a suitable environment for all women. Alternatively, staff told us women could use rooms such as the parents' room which was used by a variety of parents for other uses.

We requested data to demonstrate how the trust was working towards accreditation under the Bliss Baby charter. The trust told us they had submitted their supporting evidence to gain accreditation and were awaiting this at the time of inspection.

The trust had made improvements to the management of children and young people transitioning to adult services since our last inspection. Managers attended monthly meetings as part of the children and young people oversight group where progress of transition services was a set agenda item.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff worked with closely with the local mental health NHS trust to support children and young people who presented with mental health diagnoses. See 'multidisciplinary working' section for more details.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs. However, audit data showed staff could improve their recording of fluid and food intake.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Specialist support from staff such as dietitians and speech and language therapists was available for children and young people who needed it. Staff used care plans to identify the best way to support patients with specific needs around food.

There were dedicated children's menus in place and older children could order meals from an adult menu if they preferred. A choice of baby foods was available for young children. Staff provided food to children outside of mealtimes as required for example after a procedure.

There were meal options available which met patients' specific cultural needs and preferences.

Staff did not always fully and accurately complete children and young people's fluid and nutrition charts where needed. Managers audited nutrition and hydration. Managers monitored staff use of the Paediatric Yorkhill Malnutrition Score (PYMS) and care plans where appropriate, patients' weight being taken upon admission, children with alternate feeds having care plans, nil by mouth care plans being in place and fluid and feed charts being competed accurately. Data from the trust for Rainforest ward showed mixed results. For measures relating to PYMS; the audit score was 0% from April to July 2021 from a review of 10 patient records. This indicates staff were not using this method in this timeframe. However, 100% of records reviewed showed children had been weighed and measured on admission to a ward. In addition, where children had alternate feed plans in place; 100% had a care plan to support this. For July 2021, the audit showed 100% of fluid/ food charts were completed correctly. However, for April, May and June 2021 a score of 0% was recorded. This indicated that either there was not enough data to review, or that staff were non-compliant with this measure.

Safari ward audit data showed better compliance; all measures were 100% compliant for the same time period except for those relating to PYMS.

There was a fasting policy in place for patients awaiting surgery and were designated, 'nil by mouth'. Cold meals were available to patients returning from surgery and didn't want to wait for a scheduled mealtime.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients or parents/carers we spoke with told us they had been asked about patient pain levels.

Children and young people received pain relief soon after requesting it. We saw evidence in patient records that staff asked patients about pain; and provided medicines to relieve pain where necessary.

Staff prescribed, administered and recorded pain relief accurately. Staff supported patients to receive suitable pain management when necessary. A dedicated pain management team were available for additional advice and support.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment.

Matrons audited monthly against eight areas for staff on Rainforest ward and Safari ward. These included: safeguarding, deteriorating patient and review, infection prevention and control, risk assessments, medication, patient experience, quality, governance and safety and workforce.

The trust sent data from April to August 2021. Compliance to the audit measures varied. The service used a RAG (red, amber, green) rating system to identify if audit results were meeting expected targets (green) overall, requiring some improvement (amber) or below expected results (red).

Several audit areas consistently scored green across both wards from April to August 2021; these included safeguarding audits and infection prevention and control audits.

Some audits had data omitted so it was not possible to rate the effectiveness of the work in that area. For example, as part of the risk assessments audit, care rounding was reviewed. Several of the measures did not have sufficient data to assess this such as 'evidence of oral care'.

We saw areas which required improvement were easily identifiable. For example, as part of the care rounding audit, we saw that on Rainforest Ward from April to June 2021, only 70% of patient records showed evidence that patients had been offered a bath or a shower in the last 24 hours.

Managers shared and made sure staff understood information from the audits. The matron who oversaw the wards spoke about how data from these audits had driven improvements. For example, in July and August 2021, audits for the deteriorating patient showed poor compliance with staff completing patient observations on time. As a result, the matron spoke to staff to explore this further and worked clinically on the ward to test out any issues with taking observations. This led to changes made in practice and new electronic devices being purchased to support staff to take timely observations.

A quality matron worked across the division; their role was to develop and audit areas to drive improvement. This role enabled new pathways to be introduced to help improve quality. The matron had a focus on deteriorating patients and sepsis. We saw sepsis screening compliance for paediatric inpatients was below the 90% target in July 2021 (80% complaint for Rainforest Ward and 54.5% complaint for Safari Ward). Administration of intravenous antibiotics for paediatric inpatients was 75% in July 2021 for Rainforest Ward (3 out of 4 children received antibiotics within 1 hour) and 0% for Safari Ward (no children received antibiotics within one hour). During our inspection, we found compliance with sepsis management had improved; staff escalated patients for screening appropriately and in line with trust guidelines. Trust audit results also showed improvement, particularly on Safari Ward. For example, within September 2021, 81.4 of patients were screened for sepsis on Rainforest Ward and 81.25% were screened on Safari Ward. One hundred percent of patients audited received antibiotics within one hour.

The service took part in external reviews to assess their services. For example, the local mental health trust had undertaken a review of the children and young people's mental health service and care provision at Lincoln County. The report had not been published at the time of our inspection; however, managers told us they had received positive feedback with no significant areas for improvement.

Data provided by the trust showed that medical staff conducted clinical audits to measure outcomes against National Institute for Health and Care Excellence (NICE) guidelines and local guidelines.

The neonatal team were working through a regional action plan to support the reduction of gestational age admission from 28 weeks to 27 weeks. The plan was progressing well at the time of inspection and quarterly assurance meetings were used to assess safety, quality and performance, as well as considering clinical outcomes, morbidity and mortality.

The service was not accredited by Bliss Baby Charter. We asked the trust for data to show how they were working towards this. The trust told us they had submitted their supporting evidence to gain accreditation and were awaiting this at the time of inspection.

Competent Staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Appraisal rates were low at the time of inspection due to a change in the delivery method. Plans were in place to address this.

Full time clinical nurse educators supported staff with their professional development and knowledge. We saw staff competencies had been regularly assessed and recommendations for further training arranged when necessary. Clinical educators provided regular training sessions in the skills and competencies required to meet the needs of patients and worked flexibly to meet the needs of staff working outside of daytime working hours.

Services for children and young people

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Staff had training folders which recorded their personal development and identified further training needs. Staff said they felt confident they had the skills and provide suitable care to the patients they were asked to support.

Managers gave all new staff a full induction tailored to their role before they started work. The clinical educators gave a paediatric specific induction to support new starters' competency levels. The trust had a preceptorship programme to support new starters, newly qualified nurses and nurses who had returned to practice. This enabled staff to be supported to develop their role specific competencies within the first 12 months of their role. We noted the preceptorship booklet for staff was due to review in July 2021. Nursery nurses also worked through a similar process to obtain and record their competencies gained within their role.

Consultants provided junior doctors with an induction upon joining the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection the appraisal rate was low (22%). However, this was due to a change in the system used to record appraisals. The new system had been brought in two months prior to our inspection with a plan to start the rolling year from that point. Managers had plans to bring the appraisal rate up to the trust target. For example, a number of band six (senior) nurses were due to start non-patient facing duties and had been set the task of completing appraisals for more junior staff as a priority.

Staff had regular one to one meetings, to review their performance and promote their skills and knowledge.

Managers did not hold regular team meetings for staff. One meeting had been held via video conferencing in the six months prior to the inspection. Staff told us this was due to the pandemic.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had access to regular training and guidance.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff undertook additional training to support their roles. Managers supported staff to continue with professional development to progress within their career. For example, a member of staff who supported nurses as part of their role was undergoing training to become a registered paediatric nurse.

Managers made sure staff received any specialist training for their role. Agency nurses completed appropriate competency assessments to work with children and young people.

More than 65% of the neonatal nursing workforce had completed post-graduate training in neonates intensive care units. Data from the trust showed that as of October 2021, 22 out of 33 eligible staff had completed this. This meant a 68% completion rate against the 70% target set out in the Neonatal toolkit. The trust had a plan to achieve 73% compliance.

Staff working within theatres had completed paediatric competencies. These competencies were evolved from an ED competency pack so not all competencies were relevant to theatre staff. As a result, paediatric leads had adapted the competency pack to ensure it is more relevant to theatres.

Services for children and young people

Managers identified poor staff performance promptly and supported staff to improve. A structured approach was in place to support staff who did not meet the required levels of competency for specific areas of work.

Managers recruited, trained and supported volunteers to support children, young people and their families in the service. We observed the volunteers working within the service and saw they were familiar with the staff and the clinical areas.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Doctors and nurses reported effective team working and collaboration to provide care.

Staff within neonates told us communication and relationships with the maternity service had improved with regular meetings held.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff worked with the local child and adolescent mental health service (CAMHS) to support children and young people with mental health illnesses. Staff from CAMHS attended the wards to work with patients and a CAMHS psychiatrist was due to be based from Rainforest ward the week following our inspection.

Staff within the neonatal unit worked with a neonatal network external to the trust. Staff could access an infant feeding coordinator as required to support the neonatal band six nurses who were also trained to support breastfeeding mothers.

We saw meeting minutes which showed representation from the trust at the East Midlands neonatal operational delivery network in July 2021. The meeting minutes demonstrated evidence of local trusts aiming to develop a consistent approach to providing care and treatment.

The trust was a participant in the Midlands and East Transition Network and East Midlands Transition Regional Action Group.

The trust worked under the East Midlands Children's Cancer Network Group. Lincoln County Hospital formed part of a Paediatric Oncology Shared Care Unit (POSCU) and therefore provided inpatient supportive care (management of febrile & neutropenic child, blood products, clinical reviews) on Rainforest Ward, but not Systemic Anti-Cancer Treatment (SACT). Patients attended one of two specialist NHS trusts (a principal treatment centre) in the East Midlands to receive SACT. By being part of a POSCU, patients could receive a proportion of their cancer care at a hospital nearer to their home address.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. Staff could access the trust mental health team to provide assessment and support if the CAMHS team was not available, or a patient was exhibiting new and acute symptoms.

Seven-day services

Key services were available seven days a week to support timely patient care.

Services for children and young people

Consultants led daily ward rounds on all wards, including weekends. Children and young people were reviewed by consultants depending on the care pathway. Consultants were always available on site between 9am and 5pm. Consultants were sometimes available between 5pm and 9pm.

The paediatric wards had two ward rounds daily. Facing the Future Audit results (2020) showed that 100% of 9am ward rounds were led by a consultant and 66% of 5pm ward rounds were led by a consultant. The expected standard is 100% of ward rounds are consultant led.

Medical cover for Safari ward was by way of medical registrar Monday to Friday 8am to 5pm. Service was then covered by a medical registrar from Rainforest Ward. During peak times, the NICU registrar could be asked to support other areas.

The neonatal unit had daily consultant led ward-rounds in which parents/guardians were encouraged to attend.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Consultants provide an on-call service out of hours with a thirty-minute response time.

Mental health support was available 24 hours a day.

The play leaders worked flexible shifts to support a wider range of hours including weekends.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. The parents' room had information about common conditions and what action could be taken to improve outcomes or seek additional support and information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff mostly supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff were aware of Gillick competence principles and could describe scenarios in which this would be used. Gillick competency enables children under the age of 16 to consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment.

Staff mostly made sure children, young people and their families consented to treatment based on all the information available. Staff clearly recorded consent in the children and young people's records. We spoke with two parents whose children were undergoing general anaesthetic. Both described the information provided by clinicians including risks and benefits of treatment. One parent was able to describe the alternative treatments available and the risks and benefits of them. Both parents felt sufficiently informed of the treatment and felt they had been allowed sufficient time to reach their decision.

Records showed written consent was obtained on three occasions for surgical procedures. These included risks and benefits, type of treatment and signatures and details of relevant clinician. Signatures were obtained from a person with parental responsibility.

During the inspection, we were told by family members that interpreters had not been provided to enable parents who did not speak English to give informed consent. We reviewed two relevant patient records and found that on three occasions, there was no evidence of an interpreter being used out of a total of seven opportunities reviewed. These opportunities included medical reviews, outpatient consultations and ward admissions during which parents would be required to provide relevant patient information and give consent to various care and treatment plans.

Nursing staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data from the trust showed as of October 2021, compliance with this training was 76% against a trust target of 90%.

Medical staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data from the trust showed as of October 2021, compliance with this training was 64.7% against a trust target of 90%

Is the service caring?

Good 

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. However, on Rainforest and Safari ward, staff had to have difficult conversations in either a manager's office or the parents room due to a lack of appropriate facilities.

Children, young people and their families said staff treated them well and with kindness. Managers displayed compliments from previous patients in staff areas. Themes included caring staff.

Patients told us nurses had been very kind to them. One patient told us the doctor they saw was very funny, and they liked the doctor's humour.

Play leaders were based on both Rainforest and Safari ward; and could attend other areas to provide compassionate support to patients. We observed playworkers interacting with children and young people and saw they were kind, caring and took account of patients' individual needs.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. All staff we spoke with demonstrated a non-judgemental approach to working with children with mental health conditions. Staff were familiar with the different types of behaviour children with mental health or neurological conditions may present with and were open to working effectively with parents or carers.

Services for children and young people

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. The chaplaincy service at Lincoln County attended the ward on request from children, parents or carers.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. We observed nurses, health care assistants, nursery nurses and play leaders answer questions and provide emotional support.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. Play leaders actively worked with patients who were distressed. Staff had a good understanding and knowledge of patients who found certain procedures or care aspects distressing and requested the play leaders' support in advance; such as when a patient was due for a blood test. The play leaders had a good understanding of a range of distraction techniques; and were trained in specific neurological conditions such as autism awareness.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing. Staff demonstrated empathy and kindness towards patients and their family.

Understanding and involvement of patients and those close to them

Staff mostly supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Parents and carers gave mixed feedback about the service. Some parents gave good feedback and almost all parents highlighted that nurses had been very caring throughout their child's visit.

Parents or carers we asked praised support staff including catering and domestic team members and felt they provided a good service.

Three parents told us they had to escalate their concerns in order to get a second parent/ carer to come in to support them whilst they supported their child. The two parents told us staff did not initially permit a second person despite the parent stating they needed the support as staff were adhering rigidly to Covid-19 visiting rules. One parent escalated to the Patient Advice and Liaison Service (PALS) and a second parent had to make numerous complaints on the ward to facilitate this.

One parent said that staff did not always come and introduce themselves as their named nurse at the start of shifts and stated they did not like to use the call bell as a nursery nurse or health care assistant answered rather than a nurse. Other parents and carers said staff introduced themselves when they entered the room or cubicle.

One parent told us they felt the doctors in particular had not provided a good service and felt diagnosis and treatment had been delayed at the hospital. They told us they did not feel their child was safe whilst at the hospital and were keen to leave.

Services for children and young people

Managers undertook a monthly patient experience audit to understand patient experience. For August and July 2021, across Rainforest and Safari ward we saw positive reports which demonstrated staff were kind to patients and families, staff introduced themselves and staff gave enough information to patients and families.

Staff mostly made sure children, young people and their families understood their care and treatment. As in 'Effective', not all parents were consistently given information about their child in a format they could understand; such as via an interpreter. However, the majority of patients and parents or carers told us they understood the information provided to them including any instructions about caring for the patient.

Older children told us staff, including nurses and doctors, spoke directly to them rather than to their parent or carer.

We saw a positive example of a doctor updating a parent on the neonatal unit about their baby's care and treatment plans. However, the baby's mother was still in the maternity ward after giving birth and therefore wasn't able to listen to this. The doctor recognised this and took the parent in neonates to the maternity ward so both parents had the opportunity to listen to the plan and ask questions at the same time.

Staff mostly talked with children, young people and their families in a way they could understand, using communication aids where necessary. Staff could access picture cards to support communication.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. We saw signs displayed throughout Rainforest ward asking for feedback. Where parents or carers had raised concerns or asked questions, we found staff listened to these.

Is the service responsive?

Good ↑

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. Staff also worked with others in the wider system and local organisations to plan care. However, the facilities were not always suitable to provide a responsive service.

Managers planned and organised services, so they met the changing needs of the local population. Senior leaders worked across various clinical networks to identify changing requirements of patients in order to provide an appropriate service. An example of this was the recent change of providing care to new-borns from 27 weeks' gestation, including intensive care from a previous stance of care from 28 weeks.

Staff from the community-based child and adolescent mental health service (CAMHS) attended the ward to support patients with a mental health diagnosis, or who were known to the service.

Staff knew about and understood the standards for mixed sex accommodation. The trust policy 'eliminating mixed sex accommodation' (updated 2021) outlined that children and young people, should ideally not share sleeping areas with

patients of the opposite sex; however clinical conditions, age and other factors would take precedence over this. Staff on the wards for children and young people described working within this policy. Staff told us if a patient/ parent or carer raised this as a concern they would try to accommodate them, however this was by exception basis. Therefore, some young people may have felt uncomfortable but due to not directly raising this with staff; this was not considered.

Facilities and premises were not always appropriate for the services being delivered. The service did not have all facilities to easily support patients, parents and carers. For example, there was not a quiet room for breaking bad news for parents or having private discussions. Instead an office space was used which may not have presented the right tone when having difficult conversations.

Staff told us, and we saw, that storage space was limited in all areas.

We saw in waiting areas, a range of chair sizes to fit children of all ages were available. However, bariatric seating for parents or carers was not available in these areas, or in the parent rooms. Parents/carers had access to a chair which converted to a bed in all cubicles on the ward which was suitable for larger individuals. Some parents with young children chose to sleep in their child's bed and use a cot for the child to sleep in. Parents and carers on the ward did not have access to separate overnight facilities such as a 'flat'. However, patients had shorter lengths of stay on average at this hospital.

On the neonatal unit, there were three residential rooms for parents who were likely to be staying for extended periods or who were out of area.

Parents' rooms were available for use. These were recently re-opened and had social distancing guidance in place.

Some parents told us the signal to use their phone or the internet was poor, particularly on Rainforest ward. This made it difficult to communicate with family outside the hospital.

Some parents told us they did not receive any food provision when staying with their child on the ward. However, other parents had received meals, and we saw these being offered during our inspection. All parents/ carers were offered hot and cold drinks.

Some parents staying with their child were reluctant to leave their child to go to the toilet, use the parents' room or to purchase food from the hospital vending machines, or kiosk. These parents stated they would have liked nurses to stay with their child whilst they left the ward. Whilst nurses, nursery nurses and health care assistants did support where possible, they were not always able to do this as staff were often busy with clinical duties.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. Managers were compiling a transition policy at the time of our inspection to create a more structured process. The trust had made an application to a charitable organisation to fund a specialist transition nurse in 2020. This was not successful; however, the charity offered other support to the post holder once in place. At the time of inspection, plans to recruit for and internally fund this role had been agreed and were being progressed. Consultant paediatrician and adult transition leads were in place at the time of inspection.

Young people who were not known to paediatric services who required medical care and treatment were located on adult wards from 16 years old. For general medical care, the children and young people's managers were not informed unless there was a specific need for input.

Services for children and young people

When young people required specialised care outside of the children's' service such as maternity or termination of pregnancy; information was shared with the children and young people's team so support could be offered.

Patients had access to specific treatment pathways to ensure specialist support and treatment was provided.

Managers ensured that children, young people and their families who did not attend appointments were contacted. Staff knew the procedures if a child and their parent or carer did not attend an outpatient appointment. It was the medical staff responsibility to note this and to contact the person with parental responsibility.

Meeting people's individual needs

The service was, in the main, inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. Staff on the neonatal unit were able to signpost to post-natal mental health support. Staff had links with external support charities who provide emotional and financial support. There was a parent/guardian facilitated support network in place.

Wards were designed to meet the needs of children, young people and their families. Wards were decorated in child friendly ways for example with pictures on the walls. Privacy curtains were decorative and colourful to appeal to children and be less clinical. Staff wore colourful badges and lanyards. The neonatal unit had been re-furbished however we observed the other ward areas and the outpatient clinic had a more tired look. Managers told us they planned to re-decorate these areas in the future.

Staff placed a wipe clean colourful mat at each bedside which contained written and pictorial information for both patients and parents/ carers. This included information about where to buy food in the hospital, parking information and other practical advice.

All areas dedicated for children and young people had toys; however due to the Covid-19 pandemic the toys were being re-introduced into use. Outside of the pandemic, separate children's playrooms were available; these were just being prepared to be re-opened at the time of our inspection. As an alternative, play leaders and other staff brought toys to the children's' bedsides to ensure social distancing.

At the time of our inspection there was no sensory equipment readily available despite the unit providing regular services to children with autism, profound disabilities and learning disabilities.

Older children could use games consoles or watch DVDs available on the wards. These were attached to mobile units which could be wheeled round to bedsides. All patient beds had a small television screen which showed terrestrial channels until early evening. After this point, parents or carers were required to pay to access the tv. Other electronic devices such as tablets were available for patients to use also.

A patient told us they liked the facilities available such as the choice of games and activities. They said the room they were allocated was good.

Services for children and young people

Child friendly waiting rooms in the children and young people's outpatient clinic (clinic five) and in the orthopaedic outpatient clinic (clinic 11) were ordinarily available; again, due to the pandemic, the waiting area in clinic 11 had been changed into general waiting areas which meant children were not separated from adults whilst waiting. In clinic five, the waiting area was open, and children were free to use the toys which staff regularly cleaned.

The diagnostic department where X-Rays were taken did not have any particular facilities for children such as a separate waiting area.

Staff used transition plans to support young people moving on to adult services. If patients were known to the children and young people's service; staff designed transition plans to support young people moving to adult services. Where appropriate, young people stayed under the care of their paediatrician over the age of 18 to support their ongoing care and treatment.

Staff supported children and young people living with complex health care needs however did not use 'this is me' type documents. Managers and staff told us they did not use 'this is me' or similar documents to provide a quick and concise overview of individual children's needs, particularly children with additional needs which may have impaired communication. The trust had an 'all about me' booklet specific to adult patients with dementia.

Staff described following individual community care plans in order to support patients with learning disabilities. They highlighted the patients' specific care needs and preferences. Staff could access the local community learning disabilities team if they required additional support or guidance to meet patient's individual needs.

Play leaders provided support for all children on the wards and in outpatients. They particularly focused on patients who had additional needs as requested by nursing staff to support and/ or distract patients from unpleasant procedures or aspects of care. The play leaders were proactive and knowledgeable about how to support the needs of individual patients. They took time to get to know patients and work with them in ways which suited the patient best. For some patients, the play leaders provided age appropriate toys and supported play, for other patients the play leaders supported with homework or communication skills.

The service had information leaflets available; however, these were in English only. Patients and parents/ carers told us staff provided helpful leaflets, particularly in outpatients. Data from the trust reported there are limited leaflets available in other languages. However, there were a large number in other languages for breast feeding. The trust told us they were reviewing this in line with local networks and were in the process of launching a translation tool on the neonatal website specifically. We observed that the peer review audit conducted recently by the local mental health trust also recommended information leaflets be made available in a variety of commonly used languages.

Managers did not always make sure staff, children, young people and their families could get help from interpreters including British Sign Language interpreters when needed. All staff we spoke with knew how to access interpreters as per the trust policy. However, we found three occasions where interpreters were not used.

Staff were not always quick to respond to requests for them to use a transparent visor rather than a mask when communicating with parents who used lip-reading to understand spoken words.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. Managers showed us pictorial aids to help with communication.

Services for children and young people

Most inpatients had a short length of stay on the ward. Where school aged children attended for longer periods of time, staff organised education support from a local school. Electronic devices were available for children to access remote learning. If children were taking exams, staff provided private office space for this purpose.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. The average length of stay for patients on Rainforest Ward, the inpatient paediatric ward, was 1.5 days from July to September 2021. This was based on 833 patients attending in this time period. The maximum length of stay was 56 days in August 2021.

Outpatient clinic 11, which was an orthopaedic clinic, saw both children and adults. However, paediatric clinics were run on mostly on Wednesdays to enable children to wait with patients of a similar age, rather than amongst adults.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. The service management team identified referral to treatment times for children and young people as a risk to the service; with this not improving as quickly as was anticipated post Covid-19 pandemic. Plans including running additional clinics using a locum consultant were in place to mitigate this.

Managers monitored waiting times and made sure children, young people and their families could access emergency services when needed and received treatment within agreed timeframes and national targets. A pathway had been developed for patients attending the emergency department due to self-harm or suicide ideation or injuries in line with the children's' ward.

Managers had developed or were in the process of developing pathways with partner organisations to improve access to care. For example, oncology patients had open access to receive care or treatment for any medical concerns. An eating disorders bypass pathway had been set up for patients who had a referral from their GP or another hospital.

From June to September 2021, 14 and young people under 16 years old were placed on adult wards/areas. Eight of these were for planned treatments, and six were for emergency care.

Managers monitored that children and young people's moves between wards/services were kept to a minimum. However, when patients were admitted to Safari ward later in the evening, for example from ED, the patient could be moved again to Rainforest ward if medical staff decided an overnight stay was required. This meant an additional move for the patient. The service moved children and young people only when there was a clear medical reason or in their best interest.

Staff did not move children and young people between wards at night. Safari ward shut at 10pm; all inpatients were located on Rainforest ward overnight.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning was commenced on admission and in conjunction with parents or carers.

Services for children and young people

Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs. Managers liaised closely with community mental health teams and social services to ensure children and young people were discharged safely. If a child or young person did not have a safe home to go to due to social care concerns, managers ensured the patient stayed as an inpatient until appropriate care was arranged.

Staff supported children, young people and their families when they were referred or transferred between services. Where a very sick child was transferred, a specialist transfer team was utilised to retrieve and transfer the child. Managers monitored patient transfers and followed national standards. From October 2020 to September 2021, 72 children and young people were transferred to other providers. One patient was transferred to a specialist psychiatric unit; 71 were transferred to an alternative acute NHS provider.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. Parents and carers we spoke with gave examples of when they had raised concerns or queries.

The service clearly displayed information about how to raise a concern in patient areas. There were details of how patients and visitors could raise concerns or communicate how they found the service on Rainforest ward and also in public areas around the hospital. We found a lack of displayed information for patients or patients/carers on Safari ward about how to make a complaint.

Managers investigated complaints and identified themes. Staff could view governance boards located in managers' offices which highlighted complaint themes and trends. Managers also shared learning through divisional meetings, quarterly staff bulletins and emails. Managers shared feedback from complaints with staff and learning was used to improve the service. Data from the trust showed staff from the neonatal unit had created a colourful 'you said, we did' board to show families and carers what changes had been made following feedback.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. The service engaged with patients through gathering feedback in a variety of ways. Staff could capture patients or parents' carers views whilst on the ward via an electronic device.

Staff could give examples of how they used patient feedback to improve daily practice. Following patient and parent/carer feedback, staff produced a mat at each bedside which contained written and pictorial information for both patients and parents/carers.

Is the service well-led?

Good ↑

Services for children and young people

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The family health division had a leadership team that oversaw the children and young people's service among other clinical areas such as maternity and gynaecology. Divisional leaders told us they worked well with each other and understood the challenges they all faced around quality and sustainability of services, including staffing issues.

Local leadership was provided by matrons, ward managers and department managers. Staff spoke positively about their local leadership team and said they were visible and supportive. Matrons worked across both hospital sites; and were flexible to attend where needed daily. Ward managers said their matrons were in contact daily by phone.

Staff said local senior leaders were visible and would visit the ward and a duty manager was always available out of hours if they needed support and guidance.

At the time of our inspection, a band seven manager had just been appointed to run the children and young people outpatient services across the trust. Staff demonstrated positivity towards this and said they had been well supported by ward management prior to this new appointment.

Managers supported staff to develop by securing funding for internal and external courses, encouraging continued professional development, and by booking agency staff to enable permanent staff to be released for training.

Staff told us that the chief executive for the trust had shared information effectively during the Covid-19 pandemic enabling staff to be regularly updated.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust had a trust wide strategy for 2020 to 2025. This included the paediatric service provision. A family health divisional strategy highlighted specific goals for the children and young people service.

Ward managers spoke of the service vision for the future which included refurbishing areas within the service and having sliding clear doors in bays to improve infection control, privacy and reduce noise for patients. Staff were aware of plans to refurbish the environment.

Local managers focused on local plans within the wider health economy to build appropriate pathways for children and young people. Managers worked with local stakeholders across the regional area to ensure services offered were appropriate and sustainable.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Services for children and young people

Staff we spoke with said they enjoyed working on the ward and felt they were part of a good team. They told us they were supported to speak up and rise concerns without fear of reprisals.

Staff at all levels told us they felt supported by managers. Staff told us they felt able to support patients and focus on patients' needs.

During the pandemic, staff told us they had been asked to work in other clinical areas at times. Generally, staff told us this worked effectively; and felt they were sent to areas that suited their clinical background and competence. Staff said on occasions they had been sent to areas where they felt less confident, or felt they were expected to lead the clinical provision, such as the emergency department. Staff told us they felt confident to challenge this; and that managers supported them to address this when it happened.

Managers told us of changes to culture following staff feedback where staff reported they did not always feel appreciated. Changes included sending personal emails to say, 'thank you', rather than sending more general messages.

Managers and staff were given the opportunity to complete mental health first aid training to support patients and colleagues.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Children and young people services sat within the family health division. Managers including directorate leadership met across a variety of governance meetings to ensure information was escalated and cascaded to all staff as necessary for both the children's' wards and the neonatal unit. These were trust wide meetings and therefore included representatives across sites including Lincoln County Hospital and Pilgrim Hospital in Boston. Divisional leads had good links to the executive team enabling them to escalate information in a timely manner. A divisional executive report was produces to share information with the board as necessary.

Divisional level meetings were held monthly which incorporated other services such as maternity in addition to children and young people.

Paediatric, community paediatric and neonate unit governance meetings were held monthly. Directorate level business managers attended all three of these meetings as did the directorate pharmacist to ensure continuity.

Consultants held regular meetings to discuss performance, clinical pathway planning and staffing.

Local team meetings were held; however, these had been significantly reduced over the Covid19 pandemic. Staff told us there had been one meeting held via videoconferencing within the past six months. However, wider staff members could attend governance meetings to hear updates.

We reviewed a sample of meeting minutes across May, June, July, August and September 2021 and saw these were well attended. Regular agenda items included risks, incidents, serious incidents, complaints, staffing concerns, service improvements and other ongoing concerns.

Managers invited all staff to a monthly governance meeting. Other regular attendees included the pharmacist who oversaw the children's and young people service, the matron for the area, business managers, ward managers, clinical educators and medical staff. Where ward-based staff could not attend, any information or learning was cascaded down. For example, changes to the trust policy on fever in the under fives were shared via a PowerPoint presentation and an audit which was emailed to all staff. Where managers required confirmation that information had been read by the wider staff group, they requested confirmation via either email or a signature sheet.

Matrons and medical staff attended perinatal (during pregnancy and up to a year after giving birth) mortality and morbidity meetings and shared findings within governance meetings.

Safeguarding leads for the division demonstrated oversight of the children and young people service; they undertook record audits, delivered training and shared information to ensure all staff were aware of their responsibilities.

The service's performance was displayed in the ward. The latest information on Rainforest ward was for April 2021 and the matron for children's service told us more recent results had been received but still required displaying. This meant that staff and visitors to the ward might not get an accurate impression of the ward's latest performance and actions required to improve. We raised this with ward on staff who told us they would update the information.

The service had identified areas for improvement and action plans were in place to monitor progress. Performance information was shared with the senior leadership team by the Director of Nursing.

The matron and ward manager displayed a clinical governance board which was accessible to staff. This contained information about open incidents and themes, risks on the incident reporting system and on the service risk register, and complaints and compliment themes. This had been updated for October 2021 at the time of our visit. We saw incident themes included medicine errors; and risks included patients with mental health diagnoses and challenging behaviour, agency spend for nursing and medical staff and clinical holding (restraining children lawfully). Complaint themes included waiting times for admission. Learning following serious incidents was also displayed on the governance board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, managers did not collect all data relating to some specific risks.

The service had a corporate risk register for the children and young people service as a whole. This included one risk specific to Pilgrim Hospital; the remainder were more generalised potential risks rather than specific to the current status of the service at Lincoln County Hospital. Mitigating actions were listed to reduce risks however these were not specifically allocated or dated therefore it was not possible to tell from the risk register if these actions were being delivered at the time of inspection. Despite this, we saw managers including the directorate leadership team, matrons and ward manager had a good understanding on active risks to the service at the time of inspection and were able to talk about how these were being specifically mitigated.

Managers identified nurse staffing and agency spend as a risk. Senior managers acknowledged that the staffing levels at the time of inspection did not meet national standards. Managers were recruiting on an ongoing basis to mitigate this and had plans to prioritise certain posts such as specialist nurses. Managers also supported the internal development of staff already employed to support staffing and retention.

Services for children and young people

The service management team identified referral to treatment times for children and young people as a risk to the service; with this not improving as quickly as was anticipated post Covid-19 pandemic. Prior to the pandemic the division performed much better indicating the pandemic had negatively impacted upon the division's ability to deliver this target rather than the division generally underperforming. We saw this was a strategic objective for the division to enable all referred children and young people to be treated within the 18 week target. Plans to run additional clinics using a locum consultant were in place to mitigate this.

Lead clinicians and managers discussed performance and changes to criteria within governance meetings. For example, we saw within neonatal governance meetings; changes to admission criteria for babies were confirmed. The minutes clearly documented agreement with third party organisations to support this, additional staff training and support requirements and any potential clinical or financial risks.

Service management reviewed incidents to identify themes, share immediate learning and produce root cause analysis reports. This enabled a better oversight of areas of concern; such as medicines management. Matrons for the service told us of findings and actions from this process in order to reduce the number of incidents. We saw evidence of this within governance meeting minutes. The pharmacist with oversight for children and young people's services attended governance meetings.

Senior nurses and above received training on risk and incident management. Managers produced a quarterly 'learning to improve' bulletin which including learning from serious incidents, complaints and patient experiences. This had been produced since November 2020 and covered the family health division; therefore, staff had access to learning from incidents from other clinical areas.

Band seven nurses (ward manager and clinical educator level) held weekly huddles to share information and to discuss risk and incidents.

Staff raised concern about children being referred to Safari ward from the emergency department (ED) around 8.30pm when there would be no immediate medical cover due to doctors being at handover. They were also concerned with the patient pathway on the basis children would be moved to Safari and then again to Rainforest due to Safari closing at 22:00. In addition, ward staff also reported that because of the lack of experienced clinicians in ED, children occasionally were transferred from ED acutely unwell with little recognition of the severity of the child by ED staff.

We found not all children received medical reviews in line with The Royal College of Paediatrics and Child Health (RCPCH) guidance. The trust told us they did not routinely monitor or audit waiting times for children to have a medical review. This meant the trust did not have full oversight or assurance against this measure. However, we noted medical staff did audit this standard; last completed in 2020.

Although identified as a risk; the trust did not routinely capture the numbers of patients admitted under community and adolescent mental health care services (CAMHS). The matron had plans to start monitoring this data as part of a developing partnership with the local CAMHS. In addition, the trust provided an environmental ligature risk assessment however this was from October 2018 for both Rainforest and Safari wards. The audits stated these should be re-completed twice per year. Therefore, this audit was out of date and may not have reflected risk accurately.

Managers discussed the risk of respiratory syncytial virus (RSV) in terms of winter planning and covid-19 recovery during oversight meetings.

Services for children and young people

Information Management

Patient records were not always secured. However. The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected information and used this to analyse performance. This meant managers could easily see where improvements could be made and where the service was underperforming. Managers could review this data in comparison to other sites within the trust.

Performance information was shared and discussed at ward meetings so staff could identify any actions required to improve patient care.

Notifications were submitted to external organisations as required.

Patient records were left unsecured on two occasions which could have led to a data breach. On Rainforest ward, staff had left the door to the doctors' office open allowing inspectors to enter and review a large quantity of patients' notes unchallenged. One member of staff had also not logged out of a computer which would have allowed other people to use their account and access confidential patient information. We also saw unsecured patient records on Safari ward.

Personalised staff training records and competency assessments were stored unlocked on the ward's corridor enabling people to view staff performance information.

Staff attended daily handovers with their colleagues and the named nurses of patients they were due to support each day. This provided them with the information they required to meet the specific needs of each patient.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Matrons completed monthly audits which included patient and staff experience.

Staff audits reviewed appraisal rates, sickness rates and staff health and wellbeing. Data from July and August 2021 showed good compliance against health and wellbeing across both paediatric wards. However, an individual measure of 'staff recognition' was identified as an area of improvement. The matron told us how they had made effort to improve this element.

One hundred and eighty-one staff from the children and young people service completed the 2020 NHS staff survey. The results showed staff from this area generally felt similar to the rest of the trust. Specific areas where this core service scored lower were feeling pressured to work when unwell and 'last experience of harassment/bullying/abuse reported'. However, staff reported positively compared to the rest of the trust in areas such as not experiencing harassment, bullying or abuse from managers, patients, families or carers.

The trust collated monthly data from staff within the family health division on areas such as appraisals, wellbeing conversations, non-mandatory training, team meetings, feeling positive about working for the trust and staff experience of bullying or harassment. This enabled managers to get a wider understanding of how staff were feeling each month; although we noted the response rate was small (13%) so may not have represented the whole core service.

Services for children and young people

Data from the trust showed an August 2021 survey of the junior doctor induction to the service which showed attendees found the induction a helpful and positive process. However, it should be noted the results were from a small sample size. Patient experience included a safety, privacy and dignity audit. For August and July 2021, both wards achieved 100% across patient experience. However, results for safety, privacy and dignity were rated as underperforming. Specific issues identified included not having privacy and dignity signs on the ward.

The service engaged with patients through gathering feedback in a variety of ways. Staff could capture patients or parents' carers views whilst on the ward via an electronic device.

Managers reviewed patient, family and carer feedback to produce an assurance report which linked in with relevant risks to the service. Information was collated from 'Friends and Family Test' (FFT) results, NHS website reviews, social media reviews, cards sent in by family, and compliment and complaints sent in via the Patient Advice and Liaison Service (PALS) and complaints team.

The service liaised with external organisations to improve care and treatment for children and young people. Service representatives attended the East Midlands neonatal operational delivery network meetings. A matron had developed positive links with the community child and adolescent mental health service (CAMHS) to support patients more effectively. Some staff went into local organisations such as schools to promote services and to build trust in healthcare staff.

The service did not actively engage with the general public at the time of inspection.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

The management team, including directorate leads acknowledged that a programme of continuous improvement was underway for the service trust wide in order to mitigate risks and improve patient pathways. They spoke openly of developing the service and presented as committed to raising the profile of the children and young people service within and outside of the trust.

The senior leadership team for the service shared innovative ways to improve recruitment. This included using the certificate of eligibility for specialist registration (CESR) route to recruit doctors which enables junior doctors from abroad to go on the specialist register held by the General Medical council (GMC) as a consultant.

A nurse told us that emergency grab boxes had been introduced to the ward in response to findings at our last inspection. This reduced the need for staff to visit the emergency department for emergency medicine and equipment and therefore could respond quicker to the urgent needs of patients on the ward.

At the time of our inspection, medical staff told us no active research was ongoing. At this time, recovery from the Covid-19 pandemic was being implemented across core services which may have impacted upon the time, facilities and staff resources to structure and undertake new research.

The matron overseeing the paediatric wards across site had commenced a number of initiatives since being in post. These included engaging with a local university graphic design course to design and create unified branding and décor

for wards and the paediatric area within the Emergency Department. This was being rolled out at the time of our inspection and had not yet been implemented at Lincoln County Hospital. They had also developed, in conjunction with the local children and adolescent mental health service (CAMHS) pathways to support patients who presented with either diagnosed eating disorders or with disordered eating on Rainforest ward.

Staff within the children and young people service had opportunity to engage in continued professional development. We saw funding had been procured for autism training and advanced paediatric life support training (APLS). Some staff were being supported to gain formal university qualifications such as completing a paediatric nursing degree to develop their career.

Urgent and emergency services

Requires Improvement 

Is the service safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but did not always ensure staff were up to date with it.

Nursing staff did not always keep up-to-date with their mandatory training. The target for compliance was 90%. There were 23 mandatory training modules for staff in total; overall, the service achieved at least the target in four of the modules as of October 2021. Of the 19 modules where the target was not met, 9 modules were 75% or below, including basic paediatric life support (47%), mental capacity act (56%), safeguarding adults level three (67%) and safeguarding children level 3 (71%). However, staff had the knowledge required to ensure patients were safe.

Medical staff did not always receive or keep up-to-date with their mandatory training. The target for compliance was 90%. There were 23 mandatory training modules for staff in total; overall, the service achieved at least the target in none of the modules. All of these modules were below 75%. The modules included basic paediatric life support (21%), mental capacity act (26%), staff charter (29%) and safeguarding children level three (30%). However, staff had the knowledge required to ensure patients were safe.

The mandatory training was comprehensive and met the needs of patients and staff. Staff completed a mix of both face to face and online training; however, it was mostly online now due to COVID-19. Staff told us that the mandatory training met the needs of patients and staff.

Clinical staff did not always complete training on recognising and responding to patients with mental health needs and dementia. The compliance rates for mental health awareness training were 46% for medical staff and 94% for nursing staff. The compliance rates for dementia awareness were 61% for medical staff and 96% for nursing staff. However, staff had the knowledge required to ensure patients were safe.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had a system which would flag up a staff member who was overdue on a mandatory training module. When the service was stretched and it was difficult to complete training during the shift, staff were offered pay to complete training in their own time at home where they could access the system.

Safeguarding

Staff did not always have updated training on how to recognise and report abuse but they knew how to apply it. Staff did not always use systems to appropriately identify children who may be at risk. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Nursing staff did not always receive training specific for their role on how to recognise and report abuse. The mandatory training figures for nursing staff for safeguarding training as of (insert date) were:

- Safeguarding Children level 1 – 81%.

- Safeguarding Children level 2 - 75%.
- Safeguarding Children level 3 – 71%.
- Safeguarding Adults level 1 – 81%.
- Safeguarding Adults level 2 - 75%.
- Safeguarding Adults level 3 – 67%.

Medical staff did not always receive training specific for their role on how to recognise and report abuse. The mandatory training figures for medical staff for safeguarding training were:

- Safeguarding Children level 1 - 45%.
- Safeguarding Children level 2 - 37%.
- Safeguarding Children level 3 - 30%.
- Safeguarding Adults level 1 - 42%.
- Safeguarding Adults level 2 - 33%.
- Safeguarding Adults level 3 - 33%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Policies for the protection of adults and children were in place. They supported staff to identify different types of abuse and provided guidance on the provider's policies and procedures. Guidance supported staff to report abuse to external organisations such as the local safeguarding authority who could take action to investigate concerns. There was reference to local and national guidance and the legal responsibilities for staff. We observed good safeguarding practice take place, which included staff contacting a care worker.

Systems and processes to check nationally approved child protection information sharing systems were not embedded. We were not assured there was a system in place to check an approved national child protection information sharing system for children attending the department. This meant opportunities to review any current safeguarding risks associated with the child were potentially missed. Following the inspection, the service provided assurance this process had been in place previously and would be reinstated. Systems were in place to add an alert to emergency department electronic patient record should there be a safeguarding concern. For example, to identify children and young people who attend frequently.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to demonstrate how they would make a safeguarding referral. Staff knew how to contact the safeguarding team if they needed advice. The safeguarding team remained on site throughout the pandemic and continued to offer advice and support. Staff told us they had a positive relationship with the safeguarding team.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained on inspection. On inspection, we saw all areas of the emergency department (ED) were clean. We saw staff continuously cleaning the departments throughout the visit. Staff cleaned rooms after use before a new patient would use them. Furnishings were clean and well maintained. The service generally performed well for cleanliness.

Urgent and emergency services

The service did not always perform well for cleanliness and other areas in audits but made improvements where necessary. Monthly audits provided to us by the service following our inspection demonstrated the service did not always meet the expected infection, prevention and control standards. These audits included several areas which included hand hygiene, general environment, storage of equipment, and sharps safety. Data demonstrated from July 2021 to September 2021 monthly compliance averaged 84.58% in July, 86.83% on August and 88.2% in September 2021. When standards were lower than expected the service put actions in place, for example, when there were issues with the ceiling tiles one month which were reported in the audit they were reported to facilities and there were repaired or replaced by the next audit was undertaken.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed cleaning records over a three month period which showed all areas had been clean as per the cleaning schedule. We observed staff cleaning cubicles following patient transfer or discharge.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen following good hand hygiene practices and washed their hands when moving between patients, along with changing gloves. There was PPE and hand gel available at all entrances of the department and staff were observed changing masks and cleaning using the hand gel. There was appropriate signage in place indicating which PPE staff needed to wear before they entered a specific area or room, including rooms where aerosol generating procedures (AGPs) were taking place. The service had an appropriate room for donning and doffing PPE. We observed staff mostly using appropriate PPE during the inspection process.

Patients were routinely screened for signs and symptoms of COVID-19 when entering the department or during triage. A rapid assessment intervention treatment (RAIT) consultant was located in the reception area from 8am to midnight daily to stream patients into the most appropriate areas based on risk of COVID-19

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment after use before a new patient would use them. Equipment mostly had 'I am clean' labels on when staff had cleaned it.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use equipment appropriately. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Patients could reach the call bells in all the rooms. Staff were responsive to call bells. Patients had an accessible call bell when needed.

The design of the environment did not always follow national guidance. However, improvements had been made in order to meet to meet more of the standards. The environment standards set out in the Royal College of Paediatrics and Child Health (RCPCH) guidance, 'Facing the Future: Standards for children in emergency care settings' (June 2018) were not always being followed in the children's area of the department. The service did not have sufficient child-friendly clinical cubicles or trolley spaces to meet the need of the paediatric population including at times of peak attendance. The area was not secure with free access via the waiting room and rear entrance of ED. There were plans in place for a new dedicated children's area to be built by 2022 which would meet the national standards. The service had security staff at the front door.

Staff carried out daily safety checks of specialist equipment. We reviewed safety checks on all resuscitation, airway and sepsis kits. All were checked as per the trust policy and included all relevant equipment.

The service had suitable facilities to meet the needs of patients' families. Staff had access to a family room in the department if it was needed.

The service mostly had enough suitable equipment to help them to safely care for patients. Whilst on inspection we noticed that there were several occasions where staff were searching for an electrocardiogram (ECG) machine in order to examine a patient in the assessment area. Whilst they eventually found one, the delay took up staff time and could have potentially put patients at risk. Two out of the departments' four ECG machines were currently being repaired by the clinical engineering department.

We observed equipment was accessible and processes were in place to report equipment if it was not working. Pressure relieving mattress toppers were readily available and we saw these were used for patients at risk of pressure tissue damage. Beds could be ordered for patients where a trolley was unsuitable.

Staff disposed of clinical waste safely. We saw waste segregation in place. PPE such as aprons and gloves were disposed of in clinical waste bins. Needle sharp bins in the department were not over full and the bins were dated and signed by a member of staff.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient swiftly. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. When patients initially arrived at the hospital as walk in patients they were triaged using a nationally registered triage system by a navigator nurse who could refer patients the Urgent Treatment Centre (UTC), following on from this they would move to the accident and emergency waiting area where they would be assessed and observations and risk assessments would take place. This area would also be used as a 'fit to sit' area so patients could receive treatment in this room or wait here between assessments after triage. This only happened with patients who did not require constant monitoring or a bed.

When patients arrived by ambulance, they were seen by an ambulance nurse who took handover from the paramedics and the patient would move into the assessment area of the department, where observations and risk assessments took place. Following on from this, observations would take place at regular intervals and risk assessments would be updated if needed. Paediatric patients would also be triaged to the paediatric corridor.

Whilst improvements had been made, patients could not always access emergency services when needed and receive treatment within agreed timeframes and national targets. The service had made significant improvements in meeting national guidance by the Royal College of Emergency Medicine (RCEM) relating to the initial assessment times of patients in the emergency department (ED). From April to September 2021, an average of 82.3 were triaged within 15 minutes of arrival. Systems had been implemented to increase triage capacity in terms of additional rooms and ability to move staff to triage at busier times. The pre-hospital practitioner (PHP) role had improved to ensure all ambulance conveyances were triaged on arrival.

The number of patients attending by emergency ambulance that waited over 60 minutes from arrival to handover at County Hospital has mostly been worse than the Midlands and England averages. Between March and September 2021 there were 1,322 patients waiting over an hour. Whilst processes were in place to improve the safe care of patients waiting on ambulances, patients had to wait until there was space in the department to be assessed and treatment commenced.

Urgent and emergency services

Mental health risk assessments were not routinely completed. However, staff told us they would be completed if a patient attended with a mental health related concern of following self-harm or attempted suicide. During our inspection, we reviewed a patient care who attended following self-harm. Despite the notes indicating the patient was at 'medium' risk, there was no mental health risk assessment in place. This was escalated and the risk assessment was subsequently completed.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff carried out national early warning scores 2 (NEWS2) on adult patients, we saw these had been carried out in patients' records.

Staff carried Paediatric Observation Priority Scoring (POPS) system rather that the Paediatric Early Warning Scores (PEWS). There were plans to move to the use of PEWS, however, a date for this had not been confirmed. Children's ward based staff reported that because the department used POPS and they used PEWS on the ward, it was not always possible to ascertain the clinical condition of a child prior to their transfer to the ward.

Staff were not up-to-date with adults and children's basic life support resuscitation training. As of 28 October 2021, the service had the following mandatory training compliance rates;

- Paediatric basic life support (nursing staff) - 55% (trajectory 87% in 8 weeks).
- Paediatric immediate life support (nursing staff) – 43% (trajectory 100% in 8 weeks).
- European Paediatric Advanced Life Support (nursing staff) – 63% (trajectory 83% in 8 weeks).
- Advanced life support (medical staff) – 68%.
- Advanced trauma life support (medical staff) – 52%.
- European Paediatric Advanced Life Support (medical staff) – 50%.

Staff knew about and dealt with any specific risk issues. Staff had a good knowledge of sepsis. We observed good compliance with National Institute of Health and Care Excellence (NICE) on sepsis. In records we reviewed, staff undertook a review of the patients' sepsis status where necessary when the patients NEWS2 score was high enough. The staff used trackers which noted the patients who were at risk of sepsis or the patients who had diabetes which was located at the nurse's station. Staff had access to mattresses to help patients who were at risk of pressure ulcers. Staff used yellow socks to identify patients who were at higher risk of falls if it was identified that they were at high risk of falls in their falls risk assessment.

As of October 2021, Nursing staff were mostly up to date with sepsis training (91%), however, medical staff had poor training compliance (56%).

The service did not meet the Royal College of Medicine standard 'All emergency departments treating children should have at least one PEM trained consultant'. The service did have a lead consultant for paediatric medicine.

The service had 24-hour access to mental health liaison and specialist mental health support. Nurses made appropriate referrals to the mental health liaison team and psychiatrists when needed and sought support for patients who presented at the ED with behaviours that placed them or others at risk.

Staff did not always complete, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. During our inspection we reviewed one record of a patient. However, there was no mental health risk assessment completed to ensure the patients' needs were being met and mitigations in place to reduce risk of self-harm. This was escalated and the risk assessment was implemented. Managers told us risk assessments were normally in place, however, did not audit compliance.

Staff could not always evidence that they shared key information to keep patients safe when handing over their care to others. The service had developed a handover document which was supposed to be used when patients were moving into other inpatient areas of the hospital. This was developed in line with SBAR (situation, background, assessment and recommendations). Patients' notes were also photocopied and sent over when they were transferred. In five records we reviewed of patients who had been transferred out of the emergency department, only two had complete transfer form.

Shift changes and handovers included all necessary key information to keep patients safe. The service had both a nursing and medical handover between each of the shifts. We observed both a nursing and medical handover and they were well attended, and all the key information was shared. The handover included key messages that the senior staff wanted staff to focus on that week. Staff would then have a more detailed handover of each patients in their specific areas where they were working.

Nurse staffing

The service had some staffing vacancies. However, shifts were covered with bank and agency staff to ensure there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. Managers told us the current staffing template did not meet the demand of the service. For example, the majors' stream was particularly challenged during our inspection. One Registered nurse (RN) and one health care assistant (HCA) was allocated to cover the cubicles and walk-in patients which staff told us was challenging for them due to the variety of the role as well as number of patients they were looking after.

Skill mix was a challenge for managers due to the volume of new and junior RN's. For example, new nurses could not do triage training until they had been in post six months and some international nurses were still undertaking key competencies or were still supernumerary.

The service continued not to meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children nurses on each shift. The service had one registered nurse with level four paediatric competencies on duty 24 hours with support from a healthcare support worker. Improvements had been noted since our previous inspection. Paediatric skill mix was included on the main ED roster and the service ensured there were more than one staff member with paediatric competencies available so they could offer support if demand increased. The department had been refurbished since our previous inspection with a waiting area observable at all times by staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance as best as they could with the staff they had. Rotas were completed and reviewed regularly by a senior staff member and there was always assurance staffing levels met

national guidance. Leaders did a staffing forecast for the week ahead every Friday to ensure that they had the right establishment the following week. The senior sisters worked across sites to ensure they had the appropriate skills required at each department; this included paediatric specialist staff, paediatric trained staff and a suitable ambulance nurse. Staff would swap across sites if it was needed.

The department manager could adjust staffing levels daily according to the needs of patients. Leaders could contact the management team and other areas of the hospital or other sites if additional staff were needed. Staff could also move between different areas of the department if certain areas required additional staff. The service also made use of bank and agency staff when they were needed.

The number of nurses and healthcare assistants matched the planned numbers. On the day of our inspection, the number of registered nurses met the planned level, but the service had one less healthcare assistant. The senior sister and band seven nurses were included in the staffing numbers and working clinically to support the gaps in staffing levels to ensure all areas were covered.

The service had significant increased vacancy rates. Data provided to us by the service following the inspection demonstrated a significant increase with registered nurse vacancy rate. In April 2021 the vacancy rate was 7% which had increased to 32% in September 2021. The service was planned to meet its staffing establishment by September 2021 but due to issues with visas the service's recruitment plans were no longer on track. The adverts for nursing staff were continuing at the time of the inspection.

The service had increasing turnover rates. Data provided by the trust demonstrated in April 2021 the turnover rate was 17% and had increased to 23% by September 2021.

The service had changeable sickness rates. From April 2021 to September 2021, the average vacancy rate was 8%. The rate was higher for non-registered nursing staff which averaged 12% over the same time period.

The service had high rates of bank and agency nurses. Managers could not limit their use of bank and agency staff but requested staff familiar with the service. Staff needed to use high levels of agency staff in order to ensure safer staffing levels across the departments due to high vacancy levels. Staff used regular agency staff and at the time of inspection had block booked agency staff members. Managers made sure all bank and agency staff had a full induction and understood the service**.** Regular agency staff had access to the same systems as full time staff members.

Medical staffing

The service had some staffing vacancies. However, shifts were covered with bank and locum staff to ensure there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough medical staff to keep patients safe. Recruitment of middle grade doctors had been a challenge; however, most positions had been recruited to at the time of the inspection and awaiting start dates. Where there were shortages and demand was high, consultants would do shifts in more junior positions.

The service did have a full establishment of consultants at the time of inspection. Consultants cover was provided Monday to Friday 8am to midnight. On call cover was provided at all other times. At times of peak demand, consultants would work extended hours.

Urgent and emergency services

The service did not have a paediatric emergency medicine (PEM) consultant as recommended in the Royal College of Paediatric and Children's Health (RCPCH) guidance, 'Facing the Future: Standards for children in emergency care settings'. However, there was a lead consultant for paediatrics and medical staff working in paediatrics. The model was supported by paediatricians working in the trust and systems were in place to ensure there was a paediatrician available in the event of deterioration. The senor leadership team recognised this was an area for improvement.

The medical staff did not always match the planned number. There were gaps in the medical rota that the service was unable to fill. For example, during September 2021 there were 14 unfilled medical shifts across middle and junior grades. Medical staff told us they managed the service as safely as possible with the resources available. Medical leaders said they reviewed staffing to ensure it was 'adequate', and as safe as possible.

The service had reducing vacancy rates for medical staff. Data provided to us by the service following the inspection demonstrated a reduction in with medical vacancy rates. In April 2021 the vacancy rate was 27% which had decreased to 19% in September 2021.

The service had consistent turnover rates for career grade medical staff. Data provided to us by the service following the inspection demonstrated significant consistent turnover rates. Between April and September 2021, the turnover rate range was between 40% and 44%. There was 0% consultant turnover rate during this time, the turnover rate between all other medical grades varied between 67% and 80%.

Sickness rates for medical staff were low, however they were increasing. Data provided to us by the service following the inspection demonstrated increased but low sickness rates. In April 2021 the sickness rate was 1% which had increased to 4% in September 2021. The sickness rates had been lower and higher during this time period.

The service had continuously high rates of bank and locum staff. For example, in September 2021 there were 57 locum shifts on the junior and middle grade rota.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. Locum staff we spoke with said they had a full induction with the trust and most locum staff we spoke with were regular staff members. We saw a locum doctor reading the induction paperwork for the trust before he started his shift following on from the medical handover.

The service reviewed its skill mix of medical staff on each shift. Staffing levels were discussed at handovers and medical staff were assigned areas to work based on skill mix. had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Records

Records were not always stored securely. Staff mostly kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Patient notes were not always comprehensive, Nursing and medical staff had access to patients' paper and electronic records and all staff could access them easily. Most sections of the casualty assessment were completed. Risk

assessments were not always completed for patients with specific needs. For example, we found falls and mental health risk assessments were not consistently used for patients who required them, and transfer documentation was not regularly completed. Records were regularly updated to record two hourly care rounding. This was escalated whilst on site and the risk assessments were completed by staff.

When patients transferred to a new team, there were no delays in staff accessing their records. Paper records were transferred with patients to other departments within the hospital and electronic records were available throughout the trust. Patients who were not admitted, had their notes scanned in by administrative staff. However, patients transfer documentation was not always completed.

Records were not always stored securely. For example, on the children's corridor, records were left unattended in the corridor which meant they could be potentially be accessed by unauthorised people.

Records were not bound together which meant there was a risk of information being misplaced. records trays were not always clearly numbered, therefore a risk the wrong patient records could go in the wrong tray.

Medicines

Staff did not always follow systems and processes when storing medicines, however, they did when prescribing, administering, and recording medicines. The medicine room door was regularly left open.

Staff did not always follow systems and processes when safely storing medicines. We observed that the medicine room door was consistently left open throughout the inspection. We reported this to the senior sister who told us she was aware of the issue and attempted to remind staff regularly to close the door. This meant unauthorised people could potentially access the medicines' room. A sign had been put on the door to remind staff that it needed closing.

Fridge and room temperatures were monitored and when the temperature was out of range it was always reported to estates.

Staff followed systems and processes when safely prescribing, administering and recording medicines. Medicines administration records were maintained to show medicines that had been prescribed had administered. On medicine charts we reviewed, we found allergies were recorded in all records. Medicines were administered on times indicated and antibiotics were administered in a timely fashion when indicated.

Controlled drugs were stored and recorded following policy. Twice daily checks were undertaken, and any discrepancies were reported and investigated. We saw pharmacy team audits of controlled drug logs were regularly recorded.

Venous thromboembolism (VTE) protocols were in place and completed for patients along with appropriate prophylactic medicine

We saw information about medicines administered went with the patient to ward when they were admitted from ED.

Staff reviewed patients' medicines regularly. Medical staff recorded medicines already prescribed and when last taken on the casualty card. Any medicines administered by ambulance crew were also recorded and time administered.

Staff followed current national practice to check patients had the correct medicines. We observed staff checking patients details before administering medicines.

Urgent and emergency services

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts and medicine incidents were discussed in daily huddles.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The service had a chemical restraint policy and procedure in place. Decision making procedures were in place to aid staff to use least restrictive measures first. A rapid tranquilisation and chemical restraint checklist was in place. Medical staff we spoke to understood the procedures. Matron audits from April 2021 to August 2021 demonstrated 100% compliance with policy where patients were administered chemical sedation.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support but not always in a timely manner. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Throughout the inspection, managers and ED staff were able to demonstrate they knew what types of incidents to report and how to do so. Staff across the whole service knew who to escalate incidents to and all staff had access to the incident reporting system. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. However, three serious incidents we reviewed showed duty of candour was not always applied in line with trust policy. For example:

- Incident one – occurred and reported on 29 June 2021, and duty of candour applied on 16 September 2021.
- Incident two – occurred on 10 April 2021, reported on 10 June 2021 and duty of candour applied on 27 July 2021.
- Incident three – occurred 21 May 2021, reported 4 June 2021 and duty of candour was applied on 25 August 2021.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff notice boards contained information and learning relating to serious incidents which had occurred within the department and elsewhere. Staff told us they received feedback from incidents they reported. Staff could describe learning from historical and recent incidents which occurred at the service and other areas within the trust. For example, we observed learning was shared across sites following an incident resulting in a missed diagnosis of aortic dissection (a serious condition in which a tear occurs in the inner layer of the body's main artery). Managers debriefed and supported staff after any serious incident.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at monthly governance meetings and shared with staff at medical and nursing handovers. A newsletter was produced monthly where learning from incidents including serious incidents were shared with staff. Managers and staff told us they used social media platforms to communicate learning with staff to ensure learning was widely disseminated and consistently shared. Mortality and morbidity meetings took place bi-monthly where reviews of patient's care and treatment were undertaken, reviewed and learning shared. Feedback following medical examiner reviews was shared with staff at local governance meetings. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Urgent and emergency services

Managers completed a root cause analysis (RCA) to determine how and why a patient safety incident had occurred. Root causes are the fundamental issues that led to the occurrence of an incident and can be identified using a systematic approach to investigation. Contributory factors related to the incident may also be identified. We reviewed the previous three RCA's completed by the service. They identified areas for change and developed recommendations, with the aim of providing safe patient care. Involvement and support for patients and relatives formed part of the RCA process. There had been lots of progress with regards to incident investigation and learning since the last inspection and much of the backlog had been cleared. Managers told us that high and moderate harm incidents were investigated in a timely manner and that progress had been made with low and no harm incidents.

Staff were supported by the risk team to investigate incidents and told us they had a positive relationship with them.

Staff undertook retrospective harm reviews for all patients who waited two hours or more on the back on ambulances before being admitted into the department.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Staff showed evidence of learning from serious incidents and there were changes seen in the department. Leaders had ensured the protocols were appropriate and made staff aware of them. They also made changes to practice and introduced additional training for staff where necessary. The service also increased access to specialised teams following incidents when it was needed. Staff then audited practice to ensure it remained up to standard. Managers debriefed and supported staff after any serious incident.

The service had no never events on any wards. Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Requires Improvement 

Evidence-based care and treatment

Clinical pathways and policies were not always updated in line with national guidance. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Staff mostly followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We observed staff following best practice guidance when following up patients with potential sepsis. Nurses carried out triage assessments in an appropriate way and had completed training in competencies. This ensured they worked to evidence-based, national guidance. We observed this in practice and nurses demonstrated adherence to their system including documentation of allergies, medical history and current condition and vital signs. However, policies were not always up to date. There were occasions where the most up to date guidance wasn't followed, for example, the guideline for the assessment of acute chest pain was last reviewed in 2018 and was due to be reviewed in August 2021.

The standard operating procedure and flowchart for identification of patients presenting with potential sepsis for adults had be revised following our previous inspection.

The service had a programme of monthly quality audits to assess compliance against best practice. For example, sepsis, pain management and diabetes care. Matrons completed monthly quality audits which included reviewing records,

speaking to patients and observations. This was put into a report and triangulated with daily department assurance reports to discuss with local managers to set actions to improve through monthly confirm and challenge meetings. Two hourly nurses in charge checks were completed to assess compliance with documentation throughout the shift. Issues were addressed at the time with staff and were required support from practice facilitators put in place to support learning.

Processes were in place to protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. However, we did not see evidence these processes were fully implemented. Documentation was in place which directed staff on managing patients presenting with a mental health condition. We reviewed one set of notes for a patient presenting with mental health concerns and self-harm. However, there was no mental health risk assessment in place to determine the patients background, individual needs, risks and actions to prevent the patient coming to harm. Audits were not completed to assess staff compliance with mental health risks assessments to provide assurance they were consistently implemented.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff were aware of patients who required extra support with their mental health and wellbeing. Notes were appropriately flagged, and specific needs were discussed at handovers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed patients receiving food regularly at mealtimes, as well as food and drink being provided when requested. Staff had introduced hot meal rounds three times a day for patients who were spending longer in the department in order to provide them with better nutrition.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff had access to fluid and hydration charts in the departments and used them where necessary.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff knew how to make referrals to therapists if they were needed. These would mostly be utilised once patients moved to another area of the hospital.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff assessing patients' pain at regular intervals and saw evidence of this in patients' records. Staff used recognised pain scores throughout the patients stay in the emergency department.

Patients received pain relief soon after it was identified they needed it, or they requested it. We observed patients getting pain relief when it was requested.

Staff prescribed, administered and recorded pain relief accurately. We saw evidence of this in the patient records we observed.

Patient outcomes

Staff monitored the effectiveness and quality of care and treatment. Outcomes from national audits were not always positive and data supplied for some national audits was incomplete. Outcomes from national audits was not always used to make improvements.

The service participated in relevant national clinical audits. This included the Royal College of Emergency Medicine (RCEM) audits:

- RCEM Audit: Vital signs in adults 2018/2019.
- RCEM Audit: Feverish child 2018/2019.
- RCEM Audit: VTE in lower limb immobilisation 2018/2019.
- RCEM Audit: Assessing Cognitive Impairment in Older Adults 2019/2020.
- RCEM Audit: Mental Health (Self Harm) 2019/2020.
- RCEM Audit: Care of Children in the Emergency Department 2019/2020.

Some of the data submitted to national audits was incomplete.

The service participated in the Trauma Audit and Research Network (TARN) audit. The most recent data was published for two TARN audit measures found:

- The crude median time from arrival to CT scan of the head for patients with traumatic brain injury from January 2018 – May 2021 was 54 minutes. This takes much longer than the TARN aggregate which is 33 minutes but it met an audit standard of 60 minutes.
- The risk-adjusted in-hospital survival rate following injury out of every 100 patients, from January to May 2021 was as expected with 2.6 additional survivors.

Managers and staff did not use results from national clinical audits to improve patients' outcomes. Not all managers knew what national audits the service participated in. We did not see evidence there was regular review of national audit outcomes or actions to improve.

Managers and staff carried out a programme of local audits to check improvement over time. Regular local quality audits were undertaken, and the results were fed back into the trust’s internal quality assurance systems. Managers used information from the audits to improve care and treatment. Improvement was checked and monitored. Systems were in place to check and monitor performance against standards daily through nurse in charge audits and monthly assurance audits.

Managers shared and made sure staff understood information from quality audits but not national patient outcome audits. Audit results were shared with managers who provided feedback to staff in newsletters and daily huddles. However, we did not see evidence outcomes from national audits was shared with staff.

The service had a lower than expected risk of re-attendance than the England average. Between March and September 2021, the average re-attendance rate was 0.08%.

Urgent and emergency services

Competent staff

The service had a plan in place to make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers kept an up to date record of staff competencies they had received training and sign off for. A plan was in place to train and assess staff skills in all areas. The department was run by senior nurses who were experienced in providing emergency care. However, due to a need to increase nurse staff numbers, many nurses were junior, new to the service or were international nurses who had recently joined the services' training programme. This group of staff did not have all the necessary skills to meet all patient needs, although there was a comprehensive training programme to address this. For example, 63% of registered nursing staff had completed training in how to effectively triage patients. The service was unable to book junior nurses on until they had undergone six months in post. There was a plan for this to be completed and two staff were booked on to training in December 2021.

All eligible registered nurses with skills to work in the paediatric area within the Emergency Department had completed level four paediatric competencies. All staff had to undergo a two-day training before being signed off as competent to work with children and young people. Managers told us staff had been trained and assessed as competent to triage and assess children and young people using POPS (Paediatric Observation Priority Score) and PEWS (Paediatric Early Warning Score) and undertake an initial assessment within 15 minutes of arrival to ED.

Junior doctors were provided with opportunities for skill development. For example, ultrasound training sessions were provided.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us and managers were able to demonstrate that all staff had a fully tailored induction for each role within the service. Agency staff also received an induction to the service. New starters received additional training on ED standards.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, not all staff had an appraisal within the 12 months prior to our inspection. For example, 92% medical staff had received an appraisal, however, only 56% of registered and non-registered nursing staff had received an appraisal.

The clinical educators supported the learning and development needs of staff. The service had clinical educators in place who supported staffs educational and development needs. At the time of the inspection, the service had recently employed several new overseas nursing staff members who were at various levels of competencies who the clinical educator was supporting appropriately.

Sepsis practitioners offered coaching and one to one support for staff in identification and management of sepsis. They supported the signing off of staff competencies and attended huddles to support staff knowledge.

Junior staff spoke highly of the support they had received from practice facilitators in supporting them to develop skills and undergo competency sign off.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, newly appointed band seven nurses had been booked on to leadership training to support them in the management aspect of their role.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors had access to regular training which covered their learning needs. Weekly junior and middle grade doctors training sessions took place. Feedback from junior doctors about their experience and access to clinical supervision in the department was positive.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings could be attended in person or using video conference facilities. Team meeting minutes and outcomes or actions were shared with staff via email, social media or through a monthly newsletter. Additionally, relevant messages and updates from team meetings were shared at the daily huddles and board rounds.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, band two healthcare assistants were given opportunities to provide extended skills such as completing electrocardiograms.

Managers identified poor staff performance promptly and supported staff to improve. Poor staff performance was identified promptly. A new nurse leadership structure had been implemented in the ED which allocated a group of junior staff to a dedicated band seven nurse. This allowed close supervision of junior nurses and improved the early identification of any extra training which may be required on an individual basis.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff held meetings involving different members of staff where all the patients' needs were discussed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff at all levels and from all disciplines worked together to deliver person centred and coordinated care and support for the person with care needs. Patients in the department of the hospital had access to physio and occupational therapist support if it was required. Members of the frailty team who included occupational therapist and physiotherapy regularly visited the ward. Staff had timely access to speciality reviews.

Staff could call upon the children and young people services for advice and support and to review patients where required.

The service had developed good working relationships with the local ambulance service. We saw effective communication take place during our inspection.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We observed staff referring patients for psychological assessments when they showed signs of mental ill health prior to discharge or if they presented with mental health conditions.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. There was suitable support from diagnostic services elsewhere in the hospital such as pathology, and radiology including Computerised Tomography (CT) to support the provision of care in the emergency department. Some imaging was available in the department including plain film x-ray and ultrasound. COVID-19 testing was undertaken in the department to improve the diagnosis and segregation of patients.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff did not keep up to date with Mental Capacity Act training. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Not all staff kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance data provided to us following the inspection showed that as of October 2021 26% of medical staff were up to date with this training. Compliance was 61% for nursing staff. This was well below the trust target of 95%. However, most staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Most consent was gained verbally although we saw formal written consent was obtained when required, for example to undergo some diagnostic tests. Some staff had clearly recorded they had sought consent from a patient before carrying out an intervention. Patients provided examples where staff had sought consent.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. A capacity flow chart was included in the casualty card. We saw this was completed where there were concerns about a patients capacity, however, this was not routinely completed for all patients.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could tell us what their responsibility was in relation to decision making requirements. Staff made referrals to mental health liaison services where required.

Whilst on the inspection we reviewed any ReSPECT forms that patients had in place. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. All the patients we reviewed came in with ReSPECT forms that were in place previously.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff and managers working in the paediatric area within the Emergency Department demonstrated a good understanding of consent processes for children and young people.

Urgent and emergency services

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Applications for Depravation of Liberty Safeguards (DoLS) were not routinely completed in the department. Patients requiring a DoLS application had this completed once the patient was admitted to a ward. Patients in the ED had their best interests assessed.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good  

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interacting with patients as much as possible and staff were responsive to patients needs and responded as quickly as they could.

Patients said staff treated them well and with kindness. All patients we spoke with told us staff treated them with kindness. Throughout the inspection we observed patients being treated with kindness.

Staff followed policy to keep patient care and treatment confidential. We observed staff making effort to maintain confidentiality when talking to patients throughout the inspection.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff providing emotional support and discussing patients' wellbeing in all areas of the department. Members of the chaplaincy team also visited patients in departments, providing spiritual care as requested by patients and families.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Urgent and emergency services

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw staff engage with relatives in an empathetic way, particularly when explaining to them that they were not allowed to remain in the department due to COVID-19 visitor restrictions. We also so saw staff use the relatives' room appropriately to break bad news to patients if it was needed.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with generally reported they felt involved in their care and decisions and that staff were approachable and felt able to ask any questions they had.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff had access to communication aids if they were needed and knew where to find them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were signs around the department which explained how patients and relatives could leave feedback.

Staff supported patients to make advanced decisions about their care. We saw staff made effort to contact and include family where advanced decisions had to be made. Staff told us they would discuss with patients if they were able.

Staff supported patients to make informed decisions about their care. Staff told us they provided patients with relevant information to make a decision.

The feedback from the Emergency Department 2020 survey was positive. The trust's emergency departments scored about the same as other trusts in 25 out of 38 questions and lower than others in 13 questions.

Is the service responsive?

Requires Improvement ↑

Service delivery to meet the needs of local people

The service was mostly designed and managed in a way that always met the needs of local people and the communities it served. Managers and staff worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service had introduced strategies to ensure the patient went to the right place at the right time and to avoid unnecessary admissions. For example:

- An emergency physician in charge (EPIC) phone had been introduced which ambulance staff could have direct access to the EPIC to discuss whether a patient needed to come into the emergency department. Staff told us this positively impacted the number of patients being brought into hospital unnecessarily.
- An integrated streaming model was in place jointly with the urgent treatment centre (UTC) providers. The service had improved working relationships with the co-located UTC. Standard operating procedures were in place and managers met monthly to review how it was working in practice and discus cases which could have been seen by UTC rather than in emergency department (ED).
- The service had developed its same day emergency care (SDEC) model. The service promoted direct referrals to SDEC from GP and the ambulance service. Direct access to SDEC from 111 was introduced and an SDEC assessment tool had been implemented at triage to improve more effective signposting to SDEC from triage. Managers told is this model had positively impacted on flow. Managers acknowledged there was still work to do to further improve and increase its opening times to support out of hours.
- The trust had a frailty team which included medical staff and allied health professionals. The frailty visited the emergency department at least once a day in order to prevent hospital admissions, facilitate patient transfers or organise assessments in order improve the improve patient flow. This was consultant led.
- A pre-hospital practitioner (PHP) post had been introduced to oversee all ambulance conveyances to ensure their needs were being met and worked with the nurse in charge (NIC) and emergency physician in charge (EPIC) to ensure they were streamed to the most suitable area.
- A consultant was placed in the waiting area to support walk in flow, ensure patients were directed to the most suitable area and oversee the rapid assessment and treatment (RAT) stream.

Facilities and premises were mostly appropriate for the services being delivered. However they were limited by the environment which meant the paediatric area within the Emergency Department did not meet the required standards, although improvements had been made and plans were in place for a purpose built area to be built by 2022. This would also allow for extra assessment rooms using what was currently being used for the children's corridor.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. This was applicable to the integrated assessment unit.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. However, there was limited space in the department to accommodate wheelchairs, bariatric equipment and hospital beds.

The service relieved pressure on other departments when they could treat patients in a day. Patients were not admitted for an overnight stay unless this was required, and admission rates were monitored. A frailty team was in place to provide additional support to frail elderly patients who could go home with extra support instead. The service utilised fit to sit areas where appropriate to take the pressure off majors' cubicles. Pathways were in place to ambulatory care.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service did not allow visitors as a standard due to Covid-19, however if it was beneficial for a patient with additional needs they would allow one visitor. The service also allowed children to be accompanied by one adult. The safeguarding team had expanded to include specialist support for patients with learning disabilities, autism and dementia and they were accessible if needed. Staff have frequent attender pathways and there is a sign in patients notes to inform staff when patients are frequent attenders in the department. Staff had access to a mental health room if it was needed.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We did not see these were used during the inspection.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff were aware of communication aids that could be used for patients who had communication difficulties. Staff told us they could access sign language support.

The service did not have information leaflets available in languages spoken by the patients and local community. We did not see any information available in different languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to translation services.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Most food offered in the ED was sandwiches, plus toast and cereals at breakfast time. Hot foods had been introduced for patients waiting for long periods in the department. Staff said they had access to other food types and were able to meet patient's individual preferences, staff did three food rounds during the day.

Staff did not have access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients fell below national standards.

Whilst improvements had been made, patients could not always access emergency services when needed and receive treatment within agreed timeframes and national targets. The service had made significant improvements in meeting national guidance by the Royal College of Emergency Medicine (RCEM) relating to the initial assessment times of patients in the emergency department (ED). From April to September 2021, an average of 82.3 were triaged within 15 minutes of arrival. Systems had been implemented to increase triage capacity in terms of additional rooms and ability to move staff to triage at busier times. The pre-hospital practitioner (PHP) role had improved to ensure all ambulance conveyances were triaged on arrival.

The number of patients attending by emergency ambulance that waited over 60 minutes from arrival to handover at County Hospital has mostly been worse than the Midlands and England averages. Between March and September 2021 there were 1,322 patients waiting over an hour. Whilst processes were in place to improve the safe care of patients waiting on ambulances, patients had to wait until there was space in the department to be assessed and treatment commenced.

Urgent and emergency services

The Royal College of Emergency Medicine (RCEM) recommends patients wait no more than one hour from time of arrival to receiving treatment. The trust consistently failed to meet this standard. However, the service had consistently met its internal target of 50% to be seen within 60 minutes based on its medical staffing model. From March 2021 to September 2021, the average percentage of patients seen within 60 minutes was 51%. Performance had worsened slightly over this time as demand for the service had increased. The service had implemented systems to mitigate risks such as a consultant being placed in the waiting areas to reassess patients waiting more than 60 minutes.

Compliance with the RCEM guidance to see, treat, admit or discharge within a four-hour target was not always met. From February to August 2021, the trust's percentage of patients waiting over four hours from decision to admit to admission was among the worst three in the Midlands. In August 2021, 55% of patients waited between 4-12 hours to be admitted to a ward from the point of decision to admit. This was against a national average of 26%. Furthermore, in September 2021, 71 patients waited more than 12 hours in the emergency department from the decision to admit time.

Managers monitored waiting times. The emergency physician in charge (EPIC) and NIC undertook two hourly huddles where they reviewed all patients waiting and undertook assessments to ensure patients were offloaded from ambulances and moved to a safe area in the department according to acuity.

Escalation processes were in place to allow the ED to highlight problems with access and flow quickly. The nurse in charge (NIC) completed an emergency department risk tool hourly which used information such as number of patients waiting at different part of the system, staffing levels and acuity to assign a risk level. There were clear escalation processes as a result of the risk rating which were reported into capacity meetings.

Patients details were added to electronic system which provided managers with oversight of the department. This was used when reviewing patients. A local ambulance service electronic board was visible in the department to show times crews arrived, inbound ambulances and expected arrival times so staff are aware.

The pre-hospital practitioner role was in place 24 hours to ensure rapid and safe handover of ambulance patients. Any ambulances that were not immediately offloaded were escalated to the department site manager.

A full capacity protocol was in place which was sensitive to departmental pressures as identified through the ED risk score. The trust used the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). The OPEL level was regularly communicated within the trust and to stakeholders to ensure the wider health and social care systems were aware of the current access and flow status. We observed staff escalate appropriately.

Managers and staff worked to make sure patients did not stay longer than they needed to, however they were impacted by wider hospital and system issues. A fit to sit area was implemented so that patients who were likely to be discharged the same day could be then either discharged or transferred to ambulatory emergency care of SDEC.

The number of patients leaving the service before being seen for treatments was lower than the England and Midlands average. The service had a left with being seen rate of 5% between March and September 2021, the Midland average of 6% and England average of 6%.

Managers and staff worked to make sure that they started discharge planning as early as possible. We observed the frailty team attended the ED to assist with discharges. We observed consultants reviewing patients on ambulances with a plan to discharge where safe. There was a trust wide initiative to free up hospital beds earlier in the day and to

improve patient flow out of the ED. Daily calls were held with partner organisations in order to free up hospital beds and obtain access to continuing care for patients who required it. Daily bed meetings occurred three times a day to set actions for identifying and reviewing patients ready for discharge. Any blockages were addressed and where required senior management intervention.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff sought advice and support in discharging from the mental health liaison team. We observed a patient waiting for a mental health assessment prior to being discharged to ensure the discharge was planned appropriately to the patient's needs.

Staff did not always document their support of patients when they were referred or transferred between services. The service implemented a transfer checklist. This ensures all relevant information about the patient was shared with the incoming ward. In records we checked of recently transferred patients this documentation was only in place for two out of six patients which we saw was in place for six records we reviewed. We told the manager

Managers monitored patient transfers and followed national standards. Children and young people were transferred to other hospitals using recognised safety standards which staff understood.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff could describe the complaints process. Staff tried to resolve any issues at the time in the first instance and report it to the nurse in charge. Staff knew how to signpost to the trust complaints process.

The service clearly displayed information about how to raise a concern in patient areas. There was signage all over the department which advised patients on how to make a complaint or raise concerns if they needed to. Staff understood the policy on complaints and knew how to handle them. Staff within the service understood the complaints procedure and were able to give advice to patients on the process if they wished to make a formal complaint to the trust.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. At the time of the inspection, the service had eight open complaints, one of which was 17 days overdue. On average responses were sent to complainants within 44 days of receipt. This included a review by the complaints' manager, divisional and executive sign off. This is in line with the trust complaints' policy which states complaints will be responded to within 25 to 50 working days dependent on the complexity.

Managers shared feedback from complaints with staff and learning was used to improve the service. An action log was in place to keep track of learning actions and implementation dates. Learning and themes were shared through divisional governance meetings. Staff received feedback in daily huddles and in the departmental newsletters.

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Staff could give examples of how they used patient feedback to improve daily practice. For example, communication with patients and relatives was a common theme. The service had introduced regular patient comfort rounding which provided staff with an opportunity to update patients. The service had also recently introduced regular hot food service on the back of feedback for patients who experience long waits in the department.

Is the service well-led?

Requires Improvement 

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. The urgent and emergency care (UEC) service sat in the medicine division and was led by a divisional clinical director, a divisional managing director and divisional nurse. However, at the time of the inspection the divisional nurse position was vacant, and recruitment was underway. Urgent and emergency care leadership consisted of a clinical lead, a general manager and deputy divisional nurse who covered all three sites across the trust.

At our last focused inspection, we found leaders did not have the skills and abilities and gaps in clinical leadership had not been addressed. We found improvements had been made following our last inspection. For example, we found:

- A divisional director had been recruited to oversee and lead the medicine and urgent care division.
- A clinical lead was in post with overall responsibility for UEC across the trust and there was a clinical director in post.
- The emergency physician in charge (EPIC) role had improved since our last inspection. Training in leadership had been provided to consultants undertaking the EPIC role which covered leadership, development of situational awareness, escalation processes, rapid handover protocol, full capacity protocol and short-term rescue protocol (STRAP). EPIC training sessions were held monthly.
- The service had recruited into band seven pre-hospital practitioner (PHP) posts. This improved management of flow in the department and oversight of safety of patients.
- The service had improved its joint working between the EPIC and Nurse in Charge (NIC) role. We observed greater team work along with operations teams and the PHP to improve flow and quality of care.

The service had strengthened local leadership by recruiting into band seven sister posts. Each band seven was assigned a lead role. For example, safeguarding, IPC, flow, sepsis and clinical education. Whilst the posts were recruited into, the post holders had not yet been able to complete the leadership elements of their role due to increased demand in the department, a junior workforce and requirement to work clinically. The matron and senior sister had an extended remit and worked clinically to enhance the safety of the department and support provision of leadership.

Staff in senior leadership positions had completed leadership training. For example, the matron and senior sister had completed Royal College of Nursing (RCN) leadership courses. New band seven nurses in post were intended to complete the RCN course and had completed leadership sessions internally.

Urgent and emergency services

The Royal College of Paediatrics and Child Health recommends that every emergency department treating children must be staffed with a Paediatric Emergency Medicine (PEM) consultant with dedicated session time allocated to paediatrics. This was not in place at County hospital. Leaders told us there was a consultant who took a lead with paediatrics and there was always a consultant on duty with paediatric competencies. However, this did not meet the standards and we were not assured there was adequate leadership of the paediatric area within the Emergency Department at Lincoln County hospital.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address it. During our inspection, we interviewed the triumvirate and local leadership. They were able to tell us about current challenges and how they are addressing them. For example, medical staffing was a challenge. Leaders had a recruitment plan which meant all vacant post would be filled the beginning of 2022. Junior doctor training had opportunities for career escalation within the department. The service had a plan to sustain medical staffing by developing the certificate of eligibility for specialist registration (CESR) programme within the service. Furthermore, there were plans to apply for teaching status.

Leaders were visible and approachable. Staff told us the senior leadership team were visible. Senior managers including divisional directors and the deputy divisional nurse undertook regular walk rounds in the department. Managers told us they would support the day to day operation at times of peak demand.

The senior sister was visible and had a good relationship with staff.

Engagement workshops took place following our previous inspection with the aim of improving the working relationship between clinical, nursing and operational leads.

Vision and Strategy

The services overall vision included a specific vision at service level for what it wanted to achieve and a strategy to turn it into action. The trust vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service did not have a specific urgent and emergency care vision and set of values. However, leaders told us they were aligned to the trust strategy. The trust vision was to provide excellent specialist care to the people of Lincolnshire and collaborate with local partners to prevent or reduce the need for people to be dependent upon services. The trust had five key values underpinning its strategy including: patient-centred care, compassion, respect, excellence and safety. During our inspection we saw examples of staff enacting these values.

The trust implemented a five-year integrated improvement plan started in 2020 aimed at delivering the trust strategic objectives. This included actions in relation to the emergency departments (ED) such as medical recruitment plans which had proved successful. Furthermore, there were workstreams that would impact ED such as becoming a university hospital, enhancing data and physical capacity, improving the environment, developing the workforce and well-led services. During our inspection we saw the impact of some of these including improving the environment and improved workforce planning.

The trust had a five-year clinical strategy and delivery plan started in 2019. In it contained a brief strategy for urgent and emergency care services to:

- ‘Maintain A&E /Emergency Department services at both Lincoln and Pilgrim Hospitals, and to add an Urgent Treatment Centre at both sites.

The service had recently had a new reception area built that acted as an initial triage area for both the ED and the urgent treatment centre. By 2022 there were plans in place to have more building work done that would create a new children’s paediatric area within the department and free up additional space by utilising the current space which is used for the children’s paediatric corridor.

The trust worked alongside health and care partners in Lincolnshire to ensure the clinical strategy was aligned with their strategic direction for the county wide health and care services. System delivery lead chairs an urgent and emergency care delivery board that the trust attended.

Staff could describe the trust vision and values; however, they were not able to tell us what they were.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

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Staff felt generally supported, respected and valued. Most clinical staff we spoke to spoke highly of the support they received from line managers and other leaders. Staff told us morale was low following the previous inspection, but this had significantly improved. Junior doctors spoke highly of the support and guidance they had received from consultants.

Staff generally felt positive and proud to work in the organisation. The culture encouraged openness and honesty at all levels. Most staff described how much the service had improved and one commented it was the best it had ever been for them as a place to work. Improved staffing levels and reintroduction of students was cited as reasons staff felt more positive.

The culture was centred on the needs and experience of people who use the service. Leaders completed regular walk rounds in the department to speak to patients about their experience. Matrons spoke to 10 patients as part of their assurance audits. Staff were supportive of service changes as they knew they benefited the patient. For example, the introduction of two hourly rounding was effectively implemented as staff knew this would make the service safer for patients.

Managers took action to address behaviour and performance consistent with the vision and values. During our inspection, managers acted swiftly to address feedback provided to them. For example, feedback was given to a staff member who had not completed an assessment. This was done at time and with a learning approach to positively support improvement. Managers told us they sought support from human resources for more formal management.

There was an emphasis on the safety and well-being off staff. Matrons included staff wellbeing checks in monthly assurance audits. Senior leaders provided staff with opportunities to feedback about how they are feeling. We saw staff breaks were encouraged and managers told us they monitored the number of additional shifts staff booked. The trust wellbeing team had attended the department to support wellbeing of staff. The matron had introduced coffee, cake and chat sessions for staff.

The service introduced schemes which supported staff wellbeing and staff felt leaders supported their wellbeing. Staff had access to a room if they needed a break or a drink if they were upset, this was known as the 'wobble room'. The trust opened a wellbeing hub at the hospital, however emergency department staff were unable to leave the department to attend. Due to this the wellbeing staff came and visited the department on a regular basis allowing staff within in the department the opportunity to attend. Staff told us that leaders were always checking in on staffs wellbeing and had an open door policy for staff to approach them with any issues.

There were co-operative, supportive and appreciative relationships amongst staff. Staff and teams worked collaboratively. Staff described improvements in the collaborative working between different roles. For example, there was a mutual appreciation of roles between medical and nursing staff and we observed good team working. Staff told us managers helped when the service was under pressure.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services were generally clear. Local departmental speciality governance meetings were held as well as divisional business and clinical meetings. Clinical and business governance meetings were regular, well attended and covered a wide range of issues. For example, operational performance, complaints, incidents, training, safety alerts and mortality and morbidity meeting outcomes. The minutes were shared with staff and available electronically for anyone unable to attend. Minutes showed clear outstanding actions and included an action owner along with an expected timeframe for completion.

However, we were not assured there were clear lines of governance in relation to the paediatric area within the Emergency Department. We did not see evidence of regular paediatric updates in governance meeting minutes we reviewed, this included at both local and divisional levels within the governance structure.

All levels of governance and management function effectively and interact with each other appropriately. Local governance meetings fed into a divisional cabinet meeting which had oversight of safety and quality of the service. A divisional score card with several metrics including finance, HR, people, quality, performance was in place. This was reported by divisional leaders to executives and trust board through performance review meetings and the quality and safety oversight group.

Staff at all levels were mostly clear about their roles and understood what they were accountable for, and to whom. Although it was recognised the service had introduced a new tier of band seven sisters that had not fully embedded at the time of the inspection due to pressures to work clinically.

Processes were in place to ensure relationships with partners were managed effectively. Standards operating procedures (SOPs) were in place with the local ambulance service and urgent treatment centre. These were reviewed

regularly. For example, there were routine and regular meetings with the local ambulance service as well as extraordinary meetings to address concerns of long ambulance waits. The service attended a monthly Lincolnshire providers UEC governance meeting. This was an opportunity to assess practice against the SOPs and raised and concerns to improve joint working. Minutes contained case discussions to explore the most appropriate place for patients to be treated.

The mental health liaison nurse attended departmental governance meetings.

Management of risk, issues and performance

Risks on the risk register were not always effectively managed and not all risks were identified and escalated to reduce their impact. Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.

Divisional risk register review and oversight processes were not always effective. It was not always clear what the risk was, when the risk was added, and it was unclear who had oversight of the risk registers. Local leaders did not have ownership of the risk register therefore there was the potential for departmental risks to be missed.

Whilst most managers could describe risks, they could not always tell us what the risks were on the risk register. Whilst we saw risk registers had been updated, we did not see how the reviews linked into existing governance structures.

Day to day identification and management of risk was done using the emergency department risk tool. Processes were in place to escalate and clear actions to be taken dependent on the level of risk. Safety issues were reviewed throughout the shift by a nurse in charge who completed an assurance checklist on each shift which covered staffing, communication of safety messages, an audit of patients, controlled drug checks, infection prevention and control checks, equipment checks and key performance indicator updates. This was regularly updated and used to address an issue with performance in real-time.

Monthly matron assurance audits were completed which provided an overview of quality, performance, staffing, patient experience and staff wellbeing. This along with departmental performance indicators was discussed with the deputy divisional nurse during confirm and challenge meetings and pulled together into a score card.

Performance in national audit outcomes were not effectively integrated into the governance structures to ensure management oversight. There was a lack of interaction between patient outcome performance and internal quality indicators in working together to improve overall performance. For example, we saw limited evidence of consideration of patient outcomes and monitoring of improvements plans in governance meetings.

Incidents were not always investigated in a timely manner meaning there were potentially missed opportunities for shared learning. However, the service had made considerable progress is working through a backlog and a plan was in place to do this.

There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken in the event of a utilities failure or major incident. For example, during the inspection the electronic systems stopped working, and staff quickly implemented actions in their business continuity plan to manage the risk and maintain oversight of the department.

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Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure but not always integrated.

The service had an integrated score card which demonstrated performance across all areas of the service. Data was collected from various systems including electronic, audits, feedback from staff and patients. The information was analysed to form an assessment of risk and used to monitor performance overtime which was reported to the board. Local managers met with more senior managers regularly to set actions in response to these.

Clear and robust performance measures were used to assess quality and safety. Managers and staff knew what these were in relation to emergency department standards and patient care and safety. We saw the service used data to monitor performance against standards in real-time.

Electronic systems were used effectively to provide local leaders with oversight of the department. Large screens in the department provided staff with an electronic queue meant they could see where all patients were. This included vital information about numbers in the department and at which point of their journey. It also allowed nurses and consultants in charge to identify deteriorating patients and ensure they have been appropriately escalated.

The information systems were secure. The systems were integrated with the wider hospital but not always with partner organisations. For example, where the ambulance service was holding patients and monitoring observations, this was not on the service electronic system. This meant consultants and nurses in charge were reliant on being verbally updated by ambulance staff and pre-hospital practitioner of any signs of deterioration.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service used people's views and experiences to shape and improve the service. For example, the feedback was sought from patients' relatives and staff to formulate the integrated improvement plan. The feedback helped leaders develop key priorities and which to prioritise. The ED gathered patient feedback through the Friends and Family Test (FFT). The service participated in the annual emergency department survey and used feedback to improve. For example, the service used feedback to introduce hot food rounds for patients waiting in the department for long periods. We saw messages to staff in monthly departmental newsletters requiring staff to act in response to views of people using services.

Staff were actively engaged so that their views were reflected in the planning and delivery of services. For example, feedback was sought from staff to help shape the future new build of the emergency department due to start in 2022. During our inspection, staff were asked to complete an on-line survey to provide feedback and suggestions about improving the paediatric area within the Emergency Department. General feedback from staff was they felt senior management were more interested in their views providing them with more opportunities to feedback than previous.

The service worked collaboratively with external partners to build a shared understanding of challenges within the system. Regular meetings were held with key partners including the local ambulance service and urgent treatment centre providers.

Urgent and emergency services

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Systems and processes were in place to monitor performance. Outcomes and learning were shared with staff to improve understanding and set actions for improvement. The service had improved oversight of their performance and actions to address concerns we raised at our previous inspection had resulted in improvements. For example:

- the triage process and performance had improved.
- identification and management of deteriorating patients had improved.
- two hourly intentional rounding had resulted in improvements in patients being provided with adequate nutrition, hydration and repositioning where required.
- Improvements were noted in the management of diabetic patients across the service.
- Twelve-hour trolley waits had generally reduced.

The service had made significant improvements since our previous inspection including:

- The service acted following our previous inspection to stop central corridor care of patients being normal practice.
- Improving clinical leadership through on-going training. There was improve oversight of the department and noted collaborative working between nursing and medical leaders.
- Successful medical and nursing staff improvement. The service had started the certificate of eligibility for specialist registration (CESR) route to recruit doctors which enables junior doctors from abroad to go on the specialist register held by the General Medical council (GMC) as a consultant. This was to improve recruitment and retention.
- Improved the oversight of skill mix for both medical and nursing staff by creating rotas with skills required filling.
- Departmental refurbishments, for example, the new area for triage to either the urgent treatment centre or ED.
- Improvements in the department included regular quality audits on patient care and safety. For example, sepsis audits, compliance to escalation of sick patient protocols and mental health patient triage and assessment documentation. Some of these improvements were instigated following our previous inspections. Results from the audits largely showed an upward trend in compliance.

Managers were able to tell us areas for further improvement such as development of governance and risk register oversight, continued focus on ambulance waits, continued review of medical staffing levels to improve the number of patients seen and treated within 60 minutes of arrival. The paediatric area within the Emergency Department was also seen as a further area for development in terms of governance and staffing levels.