Good

Lincolnshire Community Health Services NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community health services for adults	Bridge House	RY5X1
Community health services for adults	Johnson Community Hospital	RY5Y7
Community health services for adults	Lindon House	RY5X2
Community health services for adults	John Coupland Hospital	RY5Y8
Community health services for adults	Horncastle War Memorial Centre	RY584
Community health services for adults	Louth County Hospital	RY5Y5
Community health inpatient services	John Coupland Hospital	RY5Y8
Community health inpatient services	Johnson Community Hospital	RY5Y7
Community health inpatient services	Louth County Hospital	RY5Y5
Community health inpatient services	Skegness Hospital	RY5Y1

Summary of findings

Urgent care services	Lincoln Walk-in Centre	RY5X7
Urgent care services	Johnson Community Hospital	RY5Y7
Urgent care services	Skegness Hospital	RY5Y1
Urgent care services	Louth County Hospital	RY5Y5
Urgent care services	John Coupland Hospital	RY5Y8
End of life care	The Butterfly Hospice	RY583
End of life care	Johnson Community Hospital (Tulip Suite)	RY5Y7
Community health services for children, young people and families	Louth County Hospital	RY5Y5
Community health services for children, young people and families	Johnson Community Hospital	RY5Y7
Community health services for children, young people and families	Bridge House	RY5X1
Community health services for children, young people and families	Gainsborough Health Clinic	RY5Z5

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Good 
Are services safe?	**Requires Improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Overall we judged the trust to be good. We identified some concerns regarding how safe services were, in particular concerns regarding staffing levels especially in community services; and a concern regarding the prescription of a controlled drug in the operating theatre at John Coupland Hospital that was contrary to trust policy.

The majority of staff utilised evidence based guidance and received suitable training and support to carry out their roles effectively. Improvements were required regarding supervision arrangements for some staff.

Feedback from patients and their carers was positive with the majority complementary about the caring nature and positive attitudes of staff and involvement in their care.

The majority of services were responsive to the needs of patients, and the majority of targets were being met or performance was improving. However, there were some gaps in children's and family services, and some specialist adult services.

The majority of services were well led at a local level as well as corporately across the trust. There were some areas of improvement in children's and family services.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of services.

Are services safe?

Requires Improvement

We identified a number of concerns regarding the safety of services, and judged this to require improvement.

Whilst staff were supported to report incidents and knew what the systems were to do so, learning that took place tended to remain local. Whist the majority of staff undertook good infection prevention measures, and premises were clean, a few staff did not follow good practice.

The majority of medicines management practices were good; however we identified concerns regarding the prescription of a controlled drug in the operating theatre at John Coupland Hospital that was contrary to trust policy.

Safeguarding was good, staff were aware of their responsibilities and training was high. Lone working practices were for the majority good, with some exceptions in the children's and families directorate.

Record keeping was of an acceptable standard, though the electronic system and wireless connectivity issues were causing frustration amongst staff and added to the length of their working day.

There were numerous concerns regarding staffing levels and the correct deployment of staff across all service areas. The trust had for the most part plans in place to recruit, but in the interim staff were working long hours and this was compounded by the concerns regarding the patient record system.

Are services effective?

Good

The majority of staff utilised evidence based guidance, and care was delivered using national quality frameworks. We judged the effectiveness of services to be good.

Pain relief was provided as appropriate for patients using end of life services, and appropriate assessments of patient need regarding nutrition and hydration were undertaken.

Most staff received mandatory training, had access to supervision and received an appraisal. However this was not universally the case and further improvement is needed particularly for supervision for some staff. A range of audits had been undertaken across the trust and quality targets met, but this was not the case for some community services for adults with long term conditions.

Summary of findings

A range of audits had taken place across the trust, though some services had limited audit activity in relation to the outcome and impact of the services they provided.

Multidisciplinary team working took place across the organisation with good links across other primary medical and secondary acute providers.

Are services caring?

Good

Overwhelmingly from patient feedback, and from observations carried out during the inspection, staff provided caring and compassionate care. We judged caring as good.

Staff maintained the privacy and dignity of patients, and involved patients as much as possible in decisions about their care, providing written information when required. Patient survey information demonstrated a high level of satisfaction with care received.

A range of emotional support was provided, and patients were encouraged to self-care where appropriate.

Are services responsive to people's needs?

Good

Overall services were responsive to the needs of patients. Services were planned to meet the needs of patients, though there were some gaps in children's and family services, and some specialist adult services. Discharge and transition arrangements were in place, and complaints were managed appropriately.

The majority of access targets were being met, and delivery in adult community services was improving, though some gaps remained.

Are services well-led?

Good

The trust had a vision and values in place and whilst many staff were aware, this was not the case for all staff. There were appropriate governance, risk management and quality systems in place that were replicated across the various business units.

Leadership locally and strategically was good, staff felt well supported and believed that the culture was open and encouraged learning and improvement. There were examples of patient, public and staff engagement, though the staff survey results had shown deterioration in the 2013 survey.

There were some examples of innovation across the different services of the organisation.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Stuart Poynor, Chief Executive, Staffordshire and Stoke on Trent Partnership NHS Trust

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; school nurse, health visitor, GP, nurses, therapists, senior managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Lincolnshire Community Health Services NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

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

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

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Lincolnshire Community Health Services NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 9 and 11 September 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 23 locations which included 4 community inpatient facilities and one walk-in centre. We carried out an unannounced visit on 10 September to one of the inpatient units.

Information about the provider

Lincolnshire Community Health Services NHS Trust delivers a range of community-based services to the people of Lincolnshire. The trust provides a range of services, which include community hospitals, minor injuries units, GP practices, out of hour's services, sexual health, services for children and families, therapies, community nursing and specialist nursing services.

Summary of findings

The trust delivers services in people's homes, primary care premises and as well as from the following main sites, of which some are community inpatient facilities:

- John Coupland Hospital
- Johnson Community Hospital
- Louth County Hospital
- Skegness Hospital

The trust employs 2,800 staff working out of a range of bases covering the whole county of Lincolnshire, an area of 2,350 sq. miles and a population of 723,000.

What people who use the provider's services say

We spoke with around 35 patients or relatives and received over 100 comment cards from people who had used services. We also accompanied staff on home visits and undertook a range of telephone interviews. Overwhelmingly patients and/or their relatives were positive about the quality of care they received, and the caring compassionate nature of staff. We received some less positive comments from parents about their lack of involvement in care their children had received from therapists.

Results for the Family and Friends Test were positive as were other patient surveys that the trust had carried out.

Good practice

- We found the care and treatment of patients and support for their families, within the hospice, the palliative care suite and throughout Macmillan and community nursing services to be good. Across end of life services staff demonstrated compassion and commitment.
- A comprehensive community nursing specification and catalogue had been introduced in 2013 which was underpinned by guidance and included eight care packages: holistic assessment; palliative care/end of life care; tissue viability; urological and bowel condition management; nutritional support; long term condition management; single intervention episodes and complex assessment and health needs management.
- A project to share specialist nursing knowledge and training with care homes in Lincolnshire had received national recognition. It received 'Highly commended' in the NHS Innovation Challenge Prize. Specialist nurses shared their skills in the areas of preventing falls, avoiding pressure ulcers and supporting continence care. A training pack was developed which was now being successfully used in other care homes across South Lincolnshire. In one care home, the changes meant GP visits reduced from 27 one month to 17 the next, there was a 50% reduction in falls and 66 % fewer community nurse visits.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider should implement the newly agreed staffing requirements and model of care across community services as swiftly as possible.
- The provider should further review staffing arrangements on inpatient units in particular Louth County Hospital and Skegness Hospital.
- Continue to develop information technology systems to enable full integration and connectivity across the Trust.
- Take action to ensure all clinical staff have access to regular protected time for facilitated, in-depth reflection on clinical practice.
- Ensure appropriate systems are in place to share learning across the organisation following incidents.
- Ensure that all premises and equipment are fit for purpose and maintained appropriately.

Summary of findings

- Address the use of verbal orders for the repeat prescription of a controlled drug in the surgical day unit at John Coupland hospital.
- Review the implementation of the 'five steps to safer surgery' to include the briefing and debriefing.
- Ensure that records are maintained and minimise the risk of duplication or inconsistent information being recorded about the patient.

Lincolnshire Community Health Services NHS Trust

Detailed findings

Requires Improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We identified a number of concerns regarding the safety of services, and judged this to require improvement.

Whilst staff were supported to report incidents and knew what the systems were to do so, learning that took place tended to remain local. Whist the majority of staff undertook good infection prevention measures, and premises were clean, a few staff did not follow good practice.

The majority of medicines management practices were good; however we identified concerns regarding the prescription of a controlled drug in the operating theatre at John Coupland Hospital that was contrary to trust policy.

Safeguarding was good, staff were aware of their responsibilities and training was high. Lone working practices were for the majority good, with some exceptions in the children's and families directorate.

Record keeping was of an acceptable standard, though the electronic system and wireless connectivity issues were causing frustration amongst staff and added to the length of their working day.

There were numerous concerns regarding staffing levels and the correct deployment of staff across all service areas. The trust had for the most part plans in place to recruit, but in the interim staff were working long hours and this was compounded by the concerns regarding the patient record system.

Our findings

Incidents, reporting and learning

Staff were aware of the systems to report incidents, accidents and near misses, and reported an open culture within which they felt safe to report such occurrences. Root cause analysis was undertaken following serious untoward incidents with actions and learning developed following this.

Requires Improvement

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There was a mixed picture across the sectors as to feedback following an incident or near miss. Many staff received feedback, and learning was shared across a team. However, learning was less frequently shared between neighbouring teams or across the different business units.

There were 395 serious incidents at Lincolnshire Community Health Services NHS Trust between June 2013 and May 2014. The majority of incidents occurred in patients' homes; 218 of the total 395 incidents. Five of these incidents related to child abuse. Evidence demonstrated that the trust had undertaken a root cause analysis in each case which highlighted lessons learnt and contributing factors. Each of the inpatient units displayed safety thermometer and harm free care information and this data was discussed by community teams during team meetings.

The trust's new pressure ulcer rate at community hospital wards fluctuated during the 12 month period between June 2013 and June 2014. The rate of new pressure ulcers had been below the England average for the last six months apart from March 2014 when two incidents of new pressure ulcers were reported.

The rate for community hospital wards was at zero for a total of six months throughout the 12 month period.

There was evidence of learning, for example, at Johnson Community Hospital, an incident last year had resulted in adjustments in staffing: bed ratios and the introduction of falls monitoring and equipment such as sensor alarms on chairs and beds.

Cleanliness, infection control and hygiene

Wards and other clinical areas that we visited as part of the inspection were visibly clean and well maintained. We did identify some concerns regarding dusty environments at Louth County Hospital; however there had been no reported cases of clostridium difficile or methicillin resistant staphylococcus aureus (MRSA) in the last 6 months. On Carlton ward at Louth County Hospital, staff were seen to be carrying 'dirty' linen along the corridor to the linen skip; this could increase the risk of infection.

Staff were observed working 'bare below the elbows', and undertaking appropriate hand washing procedures in between patient care. Infection prevention audits were carried out across the different services and those we reviewed demonstrated high levels of compliance.

Maintenance of environment and equipment

The majority of premises were well maintained, and some were built relatively recently. There were some concerns at both Louth County Hospital and Skegness Hospital which were older and awaiting refurbishment. Staff were not clear when the refurbishment at Louth County Hospital would take place, but indicated that the limitations of the current estate hindered their ability to care on occasions.

Staff within community or inpatient settings indicated that equipment was readily available. However some staff indicated equipment was less readily available after 14:00 on Fridays and over weekends in adult community services.

Records showed that equipment was well maintained, though we did note that portable appliance testing for some equipment within inpatient units was not up to date. This was brought to the attention of staff during the inspection.

We identified some out of date equipment at different locations, for example at podiatry and sexual health services.

Medicines management

Community staff within children's services demonstrated a clear understanding of the 'cold chain' processes needed to keep immunisation medicines correctly stored. Fridges were tested appropriately to ensure medicines were stored at the correct temperature.

The trust had a number of nurse prescribers including 5 within Macmillan services, and anticipatory medicines were provided for patients using end of life services to ensure their pain was managed effectively.

Controlled drugs were stored and administered appropriately. We identified one exception to this. Within the surgical day unit, although there was no evidence that patients had come to harm, there were concerns regarding the risk associated with the use of verbal orders for the repeat administration of Midazolam (Schedule 3 controlled drug). Staff confirmed that it was accepted practice in the theatre that, if the patient required a further dose of the drug and the surgeon was unable to provide a written prescription as they were operating, a verbal instruction would be accepted. Nursing staff competent to administer intravenous medication would then administer the drug. The prescription was signed retrospectively by the surgeon. This was contrary to the trusts policy for the safe and secure handling of medicines which stated that 'a verbal

Requires Improvement

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order may not be given or taken for a controlled drug under any circumstances.' We saw evidence that staff had raised this issue with the trust's medicine management team in April 2014. The issue had not yet been addressed.

Within inpatient services we observed the majority of staff when carrying out a medicines round wore red tabards to identify that they were not to be disturbed during the medicines round. This was not the case at Louth County Hospital and staff undertaking this role were interrupted. In addition we also observed nurses putting medicines into their hands prior to administration.

Records were completed appropriately and practice audits were carried out, the majority with good compliance.

Safeguarding

Staff were clear regarding the trust's safeguarding arrangements and what actions they would take should they suspect a safeguarding concern. The majority of staff had received safeguarding training, at the time of inspection it was over 95%.

The trust had a safeguarding team which included named nurses and deputy named nurses who acted as a duty team to give members of staff advice, training and planned supervision.

The 'safeguarding children and young people: roles and competencies for health care staff' intercollegiate document March 2014 stated all clinical staff such as health visitors, school nurses and paediatric allied health professionals require level three safeguarding training. Records we reviewed confirmed they had all received level three training. In some instances staff told us they were being supported to undertake level four training.

Records, systems and management

The trust had an electronic record system, which caused frustration to many of the staff we spoke with. Staff expressed concern about its effectiveness, connectivity, lack of responsiveness and the additional workload that this added on a daily basis. Staff also commented that many of the templates were lengthy and difficult to use, that there were differing templates, and they were not always able to access assessments by other community professionals as the 'share' function was not always enabled.

The trust had recognised that improvements were required to the effectiveness of these systems and the challenges of coverage in a widely remote geographical area. This was required to increase clinical time spent with patients across the organisation.

The trust was rolling out a new mobile working computer system which staff told us was meant to reduce the amount of paper records and improve information flow. Staff commented that new IT equipment had been distributed and that mobile working (inputting clinical information onto a computer at the time of patient contact) was starting in some areas. Concerns remained about the length of time taken each day to manually complete patient records and then update the computer systems at a later time. Staff cited that they frequently worked an extra five hours plus per week to ensure records were up to date. Despite the frustrations of staff; staff could understand the need for and benefit of the electronic system.

The majority of records we reviewed were all completed appropriately, though there were missing assessments within some ward and community areas. For example at Louth County Hospital we reviewed twelve patient's records and found these to be mostly completed and accurate. On 3 patient's records there were inconsistencies or gaps relating to pressure ulcer prevention. This was exacerbated by the use of both electronic and hard copy documents.

Within end of life services we reviewed 12 do not attempt cardio pulmonary resuscitation (DNACPR) forms within the hospice and the hospital ward and found that ten had been completed in line with the Resuscitation Council (UK) guidelines. Of the two that had not been completed correctly one had been photocopied and one had not been discussed with the patient's relatives. In both instances the nurse in charge was made aware.

Lone and remote working

The trust has a lone working policy in place, which staff were aware of. Staff had access to mobile phones, and buddy systems. However we did not see a consistent approach across children and family services to signing in and out of visits or a system for managers to monitor staff whilst out on home visits. These were identified as 'must do's' in the trust policy.

Requires Improvement

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Assessing and responding to patient risk

There were systems in place to respond to patient risk. In the children's and family directorate, the DASH (domestic abuse, stalking and honour based violence) risk assessment tool was used to assess the risk that a victim is exposed to and what action may be required. Staff within health visiting and school nursing services told us they had received training on domestic abuse and how to use the DASH risk assessment which they felt confident to use.

In the ward areas, patients' risk assessments were in place and recorded on SystmOne. These included pressure ulcer risk assessments, falls risk assessments, bedrails risk assessments and nutritional screening. Daily reports were provided to managers where these had not been completed or updated. We saw that care had been provided in response to identified risk. We reviewed fifteen patients records and saw that the national early warning score (NEWS) had been recorded and the escalation policy followed in the majority of cases.

There were a number of concerns identified in services for adults with long term conditions in the community. The trust had a target for the completion of a full falls risk assessment in the community for 95% of patients who required it. The trust had started recording this in January 2014 (27.3%) and was performing at 58.1% in June 2014.

The trust was not on trajectory to meet its agreed targets in 2014/2015 for avoidable pressure ulcers. These were to reduce avoidable grade 3 and 4 pressure ulcers by 50% (to eight annually for grade 4 and to 84 for grade 3) and by 80% for grade 2 pressure ulcers (to 55 annually). For example, the trust's integrated performance report for June 2014 indicated that the majority of the grade 3 and 4 pressure ulcers had been recorded in the south-west business unit with 24 acquired or deteriorated pressure ulcers noted. Additionally, each business unit's performance management regime meeting reported on pressure ulcers, for example, in one business unit there were seven avoidable and eight unavoidable pressure ulcers reported in July 2014 and it was stated that this was due to staffing issues within teams and also due to staff education.

The trust had introduced measures designed to reduce the number of serious pressure ulcers by identifying them at an earlier stage and preventing them developing. We saw evidence that for each pressure ulcer identified there was a detailed root cause analysis undertaken and the results and learning were shared with staff locally and discussed at the business units' clinical governance meetings. The trust had created a temporary senior clinical manager post to drive up performance for six months to the end of March 2015.

Staffing levels and caseload

We identified a range of staffing concerns across the services we inspected. There was a wide range of vacancies that needed recruiting to.

Staff sickness was higher than average (rated nationally as in the worst 25% of community provider trusts) between the period of April 2013 to December 2013. The trust's June 2014 performance report indicated that the sickness absence rate target for the trust was 3% or less and it had been non-compliant for the year to date. However, within the community business units the rates were better than overall with long term sickness being 2.2-3% and short-term sickness being 1.4-2.4%.

The staff survey for 2013 indicated that the percentage of staff working extra hours was 76% which is higher than the national average of 71%. Most staff we spoke with told us they had been working extra hours most weeks. Examples included community nurses regularly working five hours extra per week to ensure that the records were up to date. A team leader also told us they routinely worked the same hours as 1.5 whole time equivalent staff.

Throughout end of life services, we were told of issues around shortages of staff and increased caseloads as a result. Trust wide the head count for Macmillan services was 15 nurses. Staff told us of one band six and one band seven (whole time equivalent) vacancies and gave examples of managing caseloads of approximately 40 to 60 patients each and not always being able to dedicate the time they wanted to their visits. Staff also indicated a lack of administrative support which meant they spent time on administrative duties rather than clinical care.

The trust's annual report for 2013/2014 stated that for community hospitals, staffing levels were identified using the Royal College of Nursing formula for ward level staffing for care of the elderly which identified a ratio of one nurse to nine patients in the day and one to eleven at night. We found there was a varied level of staffing and response to concerns across the community hospital wards. The wards at Johnson Community Hospital and John Coupland Hospital had temporarily reduced the bed base in response to staffing and patient safety concerns; this was not the

case at Louth County Hospital and Skegness Hospital. The staffing levels at Louth County Hospital and Skegness Hospital were below the staffing levels identified by the trust.

Board minutes indicated that evidence based models had been used to underpin the staffing requirements for community services including the Department of Health Long Term Conditions pathway and population profiling and the NHS Scotland efficiency modelling and workforce planning models by Hurst (2006) and Buchan (2000). This work had established that there was a deficiency of band 6 (case managers) and band 3 (health care assistants) staff which was being addressed by a workforce transformation programme. The percentage of vacancies across the trust had shown an overall decrease over the last 12 months from 9.7% in April 2013 to 5.2% in May 2014.

Evidence from community services for adults with long term conditions indicated that there were deficits in staffing levels in some areas which were impacting on patient care. For example the north-west business unit (NW BU) clinical governance and scrutiny group minutes indicated that the NW BU had a deficit of approximately 14 whole time equivalent (WTE) posts and that it was under established by 4.8 WTE band 6 case managers, 5.5 band 5 nurses and 4.4 WTE band 3 support workers. In addition the teams were (in July 2014) carrying approximately four band 6 case manager vacancies with two WTE vacancies being covered by band 5 staff due to undertake district nursing training in September 2014. The staffing deficits meant staff working excess hours and working extended shifts.

In children's and family services a common theme emerged from staff who told us they did not understand the workforce tool that was being used and how this was used to inform teams and caseload numbers. Staff were also unclear on the actual number of staff which were required for their caseloads.

In 2011 the health visitor implementation plan (DH) identified the government's commitment to increase the number of health visitors nationally by 4,200, to be reached by March 2015. For Lincolnshire community healthcare services this meant there would be an increase to 134.5 whole time equivalent (WTE) health visitors by March 2015 working in the trust. This overall number of health visitors would include health visiting staff in the trust working in other roles and who may not have face to face contact with children. The trust anticipated approximately 120 wte HV's would be working directly in the health visiting service and having face to face contact with children.

We were told by the trust before the inspection that from the 1st September 2014 there would be 115.5 (WTE) Health visitors working in the health visiting service and the current health visitor caseloads were 344 children per wte health visitor. Lord Laming (2009) in his report on the protection of children in England stated health visitor caseloads should be no more than 400 children. The community practitioner and health visitor association (CPHVA 2009) made further recommendations that 400 should be a maximum caseload and 250 was the ideal caseload number for any health visitor.

We spoke with senior managers including the general manager and the head of clinical services about the concerns over staffing and caseload numbers. There was confusion over the number of health visitors actually working within the health visiting service and having face to face contact with children. During our inspection we found there were large differences between the caseload numbers health visitors were working with. We asked senior managers about this who confirmed staff had not been deployed in the 'right places' across the health visiting service. For example;

- North West 1 team (Fen House) had 2,950 children on the caseload and there were currently 5.89 wte health visitors in post. This would increase to 7.69 wte in October with new staff starting. This meant there would be 383 children per wte health visitor.
- North West team 2 (Birchwood) had 1,778 children on the caseload and there were 3.7 wte health visitors allocated to this team. This meant there were 480 children per wte health visitor. When we met with the team leader and operational lead they told us two of the health visitors were off sick so this left the team with 1.7 wte health visitors. Support was being provided in the short term by staff from other teams.
- South East team 1 (Boston) had 6,194 children on the caseload and there were 6.4 wte health visitors allocated to this team. This meant there were 967.8 children per wte health visitor. Support was being provided in the short term by staff from other teams and there were plans to move additional staff into this team.

Requires Improvement

Are services safe?

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- As of 1st September 2014 there were 39,744 aged 0-4 in the health visitor service. Following our inspection the trust provided further information on the total number of health visitors in universal services. As of 1st October 2014 this would be 83.47wte. This meant across the trust the average caseload sizes per wte HV would be 476 children.

Since the inspection the trust has provided updated information regarding caseload numbers and staffing establishments. In most teams this has meant an improvement in the number of children allocated per health visitor.

There was an active and on-going recruitment programme to recruit health visitors to work within the trust with 7.6 wte health visitors due to start within the next 3 months and a further 10 student health visitors who had been offered posts when their courses finished in January 2015.

School nursing teams consisted of school nurses, registered nurses and assistant practitioners. The same mapping tool used in health visiting was also used in school nursing to review activities and match the appropriate member of staff with the skills and competencies to undertake the task.

The trust had an active programme of development to increase the number of specialist community public health practitioners (SCPHN) within school nursing. Over the previous three years the trust has reduced the deficit of SCPHN's required according to service mapping from 9.2 wte to 2 wte. This has been managed by supporting nurses into training on a full time or part time basis. At the time of inspection there were four SCPHN's in training. The total number of SCPHN's in post was 16.82. There was a current advert for 1 wte SCPHN post at the time of our inspection. According to the resource mapping tool the family and healthy lifestyles business unit required 19.92 wte SCPHN's to meet the needs of the family and healthy lifestyles business unit.

In 2004 the Department of Health (DH) in their white paper Choosing health: making health choices easier committed to the provision of 'at least one full time, year round, qualified school nurse for each secondary school and its cluster of primary schools' (school pyramids). The CPHVA (2013) further recommended there should be one full time public health qualified school nurse (SCPHN) for every secondary school and its cluster of primaries with additional qualified school nurses or community staff nurses according to health need. We were told by one of the Band 7 SCPHN's there were 84 secondary schools across Lincolnshire.

During our inspection we reviewed the caseloads and staffing establishments. For example;

- In the Louth team there was 1 part-time SCPHN on a 39 weeks a year contract, with a team of staff nurses, assistant practitioners and health care support workers. There was also a SCPHN vacancy within the team. Staff told us there were eight secondary schools and 42 primary schools on this caseload.
- In the Sleaford team there were 2 SCPHN's supported by a team of staff nurses, assistant practitioners and health care support workers. Within this caseload there were four high schools and 21 primary schools.
- At the focus groups staff within the school nursing teams told us they felt they did not have enough SCPHN's to meet the needs of the local population.

Within therapy services staff told us there was no capping on caseloads and there was an expectation numbers would be absorbed by the teams. Staff told us they worked across the different geographical areas of the trust to meet the needs of the service and this sometimes meant they were travelling large distances between contacts. The family and healthy lifestyles business unit provided information on what they expected average caseloads for services to be;

- For a band 5 physiotherapist they would have a caseload of less complex children who would be reviewed in clinics. This would equate to approximately 120 children and young people and they would be expected to see 22-25 face to face contacts a week.
- For a band 6 occupational therapist they would have approximately 60 children and young people and they would be expected to see 12-15 face to face contacts a week.
- For a speech and language therapist who had a day per week in a clinic the caseload for that clinic would be 60 – 70. Additional time was put into clinics during school holidays.

Deprivation of Liberty safeguards

Staff demonstrated an awareness of deprivation of liberty safeguards. No-one was subject to a deprivation of liberty

Requires Improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

safeguard at the time of inspection. Guidance regarding assessing mental capacity of patients was available. Staff demonstrated a good awareness of the Mental Capacity Act.

Consent

Staff were aware of when and how to use Gillick competency and Fraser guidelines. Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. Since then, they have been more widely used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions. Staff within school nursing were able to give examples of how they used the competencies.

Managing anticipated risks

Within inpatient areas, major incident policies and contingency plans were in place and staff demonstrated an awareness of these. There were systems in place to identify individual patient evacuation requirements in most areas and systems in place to ensure this was communicated to staff.

There had been recent changes to the structure of the trust's risk register, which while providing better clarity for the board and executives, meant that staff were less clear what the current risks were in their clinical area (please refer to governance in the well led domain for further information).

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

The majority of staff utilised evidence based guidance, and care was delivered using national quality frameworks. We judged the effectiveness of services to be good.

Pain relief was provided as appropriate for patients using end of life services, and appropriate assessments of patient need regarding nutrition and hydration were undertaken.

Most staff received mandatory training, had access to supervision and received an appraisal. However this was not universally the case and further improvement is needed particularly for supervision for some staff. A range of audits had been undertaken across the trust and quality targets met, but this was not the case for some community services for adults with long term conditions. Some of the trust's quality targets were not being met.

A range of audits had taken place across the trust, though some services had limited audit activity in relation to the outcome and impact of the services they provided.

Multidisciplinary team working took place across the organisation with good links across other primary medical and secondary acute providers.

Our findings

Planning and delivering evidence based care and treatment

Staff utilised evidence based guidance across all services. There were trust wide processes in place to share National Institute of Health and Care Excellence (NICE) guidance as it was received. There was some variation in inpatient services, where staff reported that they sought this information themselves, and some guidance we noted used out of date evidence. In end of life services staff followed the Gold Standards Framework; and records indicated that patients received care that followed National Institute of Health and Care Excellence (NICE) QS13, a standard which defines best practice in end of life care.

The trust's children's and family services delivered the healthy child programme and initiatives such as UNICEF's baby friendly initiative.

Pain relief

Staff in end of life services followed NICE quality standard CG140 for the provision of effective prescribing of strong analgesia for pain control in palliative care.

Nutrition and hydration

Patients were assessed appropriately within inpatient wards, and as appropriate within community settings. Audits confirmed that assessments were taking place. The children's and family service had developed a breast feeding web site to encourage breast feeding across the county as part of breast feeding awareness week in August 2014.

We observed a number of meal times. For the majority, patients were not interrupted during meal times, but this was not always the case at Louth County Hospital.

Telemedicine

Telehealth services were in place across a number of areas in the trust, which supported patients to monitor their own conditions and seek telephone support when required. At one of the trust's end of life locations they were due to commence a six month pilot involving remote diagnosis and treatment as part of the 3millionlives Programme, involving local GP's and the local accident and emergency department of the acute hospital.

Approach to monitoring quality and people's outcomes

A range of audits took place across the trust, though not all had taken place that had been identified in the trust's annual clinical audit plan for 2013-2014, and not all services had undertaken audits to judge the impact of the care delivered.

Quality review targets in end of life services were being met. Within community services for adults with long term conditions, of the eight CQUINs (Commissioning for Quality and Innovation) agreed for 2013/2014 the trust achieved three; partially achieved two; and failed to achieve three. Those they failed to meet related to the friends and family test, dementia screening targets and clinical supervision.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

In children's and family services from July 2013 to June 2014 the health visiting service had only managed to achieve between 6% and 24.95% against a year to date target of 60% of its antenatal contacts.

Competent staff

There were formal processes in place to ensure staff received supervision and training. The majority of staff had received mandatory training, though there were some staff who indicated that access was difficult either due to low staff levels, or a lack of frequency of training for specific courses.

Many staff had had an appraisal, and whilst levels were low in places, partially due to changes in the appraisal process, plans were in place to ensure staff were appraised appropriately.

Staff in the children's and family directorate received safeguarding supervision as appropriate, though clinical supervision amongst other groups was more variable. The trust had introduced a new policy for supervision for the year 2014/2015.

Multi-disciplinary working and working with others

Multi-disciplinary team working was evident across the trust; we observed multi-disciplinary team meetings taking place, including those following the Gold Standards Framework in end of life services.

In children's and family services for example, the named nurse for vulnerable children and young people attended various meetings and forums which involved multi-agency partners such as the looked after children's steering group and partnership board meetings

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

Overwhelmingly from patient feedback, and from observations carried out during the inspection, staff provided caring and compassionate care. We judged caring as good.

Staff maintained the privacy and dignity of patients, and involved patients as much as possible in decisions about their care, providing written information when required. Patient survey information demonstrated a high level of satisfaction with care received.

A range of emotional support was provided, and patients were encouraged to self-care where appropriate.

Our findings

Compassionate care

We spoke with a range of patients and relatives during the inspection and attended home visits in the community. We received over 100 comment cards and observed telephone consultations taking place. Overwhelmingly patients and the relatives spoke positively about the care they received from staff.

Patients described staff that were passionate regarding the quality of care that they provided, and the compassion and empathy shown by end of life care staff and Macmillan nurses.

Dignity and respect

The care we observed being delivered was done so whilst maintaining the dignity and respect of the patients involved. Privacy curtains were used suitably within clinical settings, and staff spoke to patients appropriately at all times.

In ward areas within single rooms staff sought permission to enter rooms, and conversations with patients were kept discrete.

Patient understanding and involvement

The majority of patients told us that they felt involved in their care, and where appropriate their relatives were also involved in treatment decisions. Information was provided to patients and interpreting services were available as required.

A survey carried out by the Picker Institute in 2013 of over 1000 patients found that 91% rated their overall experience as “excellent” or “good”. Most respondents felt that the information that was provided was helpful and they were as involved in decisions as they wanted to be; 97% felt they had been treated with dignity and respect; 89% of those surveyed were also happy with the frequency of appointments and visits.

Emotional support

Staff provided emotional support to patients and their relatives across the services we inspected.

A range of staff were available to provide patients and their relatives with emotional support in end of life services, including clinical psychologists. Overnight accommodation was available in the hospice run by the trust, and post bereavement support was offered by Macmillan staff to bereaved relatives.

Within the school nursing service, draft guidelines had been developed to support the school nurse in the management of children and young people who self-harm, in the management of children and young people who were suffering from depression and in the management of children and young people with eating disorders.

Promotion of self-care

Patients were actively encouraged to become involved in their care and to self-care. Information was available for patients regarding their condition and those who received telehealth services were supported to self-care.

Inpatient services provided rehabilitation care and patients told us that they were encouraged to self-care but received assistance from therapy and nursing staff when required.

Within end of life services, staff told us of the HOPE (Helping Overcome Problems Effectively) programme, a six week programme run in conjunction with a university and a registered charity. The programme was free to participants and the Macmillan nurses identified patients that might benefit, the aim of the course was to enable patients to manage the day to day impact of their condition. Feedback from a course held during October and November 2013 was either good or excellent.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Overall services were responsive to the needs of patients. Services were planned to meet the needs of patients, though there were some gaps in children's and family services, and some specialist adult services. Discharge and transition arrangements were in place, and complaints were managed appropriately.

The majority of access targets were being met, and delivery in adult community services was improving, though some gaps remained.

Our findings

Service planning and delivery to meet the needs of different people

Across the trust services were planned to meet the needs of patients in the majority of cases, though there were some exceptions. End of life services had specific referral criteria for both the hospice and palliative care service, and Macmillan nurses had close links with other specialist nurses across the trust in order to manage non-malignant conditions.

Admission criteria and pathways were in place for inpatient rehabilitation services; the service was able to meet the needs of patients that were referred to it. In adult community services, whilst the majority of services were planned to meet different needs, the trust was aware of the challenges that this brought given the rurality of much of the organisation's geographical area. There were some examples where there was a lack of specialist support e.g. Parkinson's disease specialist nurse in the north and a lack of community based intravenous antibiotic service.

Within children's services, the school nursing service had identified a lead to work with education colleagues to support children and young people not currently in education, but at the time of inspection this was a gap in service provision. Health assessments were carried out for looked after children, and the Family Nurse Partnership team who had recently been set up were continuing to develop and recruit further clients. Whilst there was an enuresis clinic for nocturnal bed-wetting problems there was not a service commissioned for children and young people who suffered similar problems during the day. The trust provided us with information about the other services available. School nurses would give general advice and support regarding toilet training programmes for children with delayed development/special needs and refer the child or young person to their GP as necessary.

Access to the right care at the right time

Access to the urgent care centres and walk-in centres were effective and they had met the four hour target to discharge, admit or transfer patients. The 15 minute hand over target between ambulance service and trust was also being achieved. The majority of patients were admitted to inpatient wards via the trust's central contact centre that had access to information to manage waiting lists and bed vacancy numbers.

End of life services were available 24 hours a day 7 days a week, which included effective out of hours arrangements with other providers including the independent sector. A green card scheme had been launched by a local charity for patients to show if they attended out of hours accident and emergency services which indicated that they were accessing end of life services.

In children's and family services the referral to treatment time targets were being met, but staff indicated that there was often a long waiting time to access follow up appointments after this. Staff in school nursing particularly raised concerns about how responsive they could be meet the needs of children and young people as staffing capacity did not allow them to be as flexible as they needed to be. At the time of inspection there were no waiting lists for access to services with the exception of the Lincoln area where there was a 12 week wait for children or young people to receive individual packages of care.

The trust had opened a contact centre (single point of access) and rapid response team at the end of 2013. The contact centre could refer to the rapid response and independent living teams as well as community staff. Performance of adult community services had been improving since April 2013 but in a number of cases was still below the target for example, urgent assessment with 24 hours stood at 94.4% (target 95%) in June 2014 from a starting point of 80.9% in April 2013.

Discharge, referral and transition arrangements

Referral and discharge arrangements were in place for patients receiving end of life services. There was a fast track

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

discharge process for patients who were nearing the end of their lives. Staff in rural areas of the trust raised some concern regarding access to carers to provide personal care for patients. This was not an issue in urban areas.

The multidisciplinary team were involved in planning the discharge arrangements for inpatients, and we observed patients being involved in their discharge planning. A number of staff had been employed to manage the discharge process within the various hospitals. Data indicated that on average between December 2013 and May 2014, 4 patients' transfers of care were delayed each month all for non-acute patients.

There were transition pathways for children and young people from therapy services, and the health visiting service had implemented a transition handover between the midwifery and health visiting service. Handover arrangements were in place between health visitors and school nurses.

Responding to and learning from complaints and concerns

Staff we spoke with were aware of the trust's complaints systems and processes. Staff endeavoured to deal with concerns raised by patients or relatives at the time they occurred. Information was available and displayed for both the complaints process and the patient advice and liaison service. Between December 2013 and June 2014 there were 97 complaints trust wide; the majority were in respect of community services.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Instructions

The trust had a vision and values in place and whilst many staff were aware this was not the case for all staff. There were appropriate governance, risk management and quality systems in place that were replicated across the various business units.

Leadership locally and strategically was good, staff felt well supported and believed that the culture was open and encouraged learning and improvement. There were examples of patient, public and staff engagement, though the staff survey results had shown deterioration in the 2013 survey.

There were examples of innovation across the different services of the organisation.

Our findings

Instructions

Vision and strategy for this service

We found variation in the level of understanding of the trust values and visions in the services we inspected. The trust values were listed as FIRST: focus, impact, respect, safety and teamwork. Most staff were able to quote these values and we found that their practice, attitude and commitment reflected them.

Staff were less able to describe the vision and strategic objectives of the trust. In the specialist services most staff were able to articulate the vision for their individual service.

Staff were aware of the introduction of the new neighbourhood teams in adult community services, but unsure as to how all the services fitted together under this new model. The vision and values were often seen displayed on notice boards within inpatient wards.

Staff from Macmillan services were able to tell us about a range of developments that they wanted to introduce to the service, but felt the trust lacked an overall strategy for Macmillan services. There were similar concerns within children's and family services. We were told that the service was currently developing a vision; some staff were aware of the national health visitor implementation plan but were less clear on how the service was implementing the plan or timeframes to achieve this.

Governance, risk management and quality measurement

The trust had an updated risk management strategy and staff that we spoke to were aware of the processes described within it. Following internal audit recommendations, significant changes had been made to the trust's risk register. In January 2014 all existing risks were reviewed and merged into thematic risks. The risks were well articulated in terms of condition and consequence although the cause was not always easy to identify. The risk ratings were consistent, with realistic target risk ratings assigned to each risk.

The heads of clinical services and trust board members we spoke to told us that this new approach was making it much easier to manage the risks and avoided duplication. We were also told that new risks were still added from the services via a risk assessment sent to the heads of clinical service and clinical governance manager. However for clinical staff this new approach meant they were less clear of all the risks in a particular service, or where similar risks had been identified across different teams.

Each of the business units held regular governance and performance meetings where risks and quality were discussed and performance reviewed.

The agendas for the quality and risk committee, quality scrutiny group and the business unit governance groups all had the same standing agenda items, which helped with the audit trail of risks or issues being escalated. The heads of clinical service were committee members of all three committees. The agenda items were also RAG (red, amber, green) rated in terms of assurance received by the committee.

The trust had made improvements in Monitor's quality governance framework. The latest external report undertaken gave a score of '3' (a score of 3.5 or less is required for aspirant foundation trusts to progress an application). The improvements were around monitoring the risks to quality and stakeholder engagement.

Leadership

Staff across all the services told us they had good local leadership. Staff spoke highly of the new chief executive,

Are services well-led?

Good

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and how accessible the chief executive had been since starting in the organisation 11 weeks previously. Staff also noted the impact of the deputy chief nurse in supporting them to improve the quality of services.

Many staff were supportive of the clinical senate that had been established to improve the voice of clinical staff across the organisation, though therapy staff raised concerns regarding the lack of a senior therapy lead at board level.

Culture across the provider

Staff reported an open culture across the trust; they were encouraged to report incidents. Many staff had been involved in the 'time to care' project. The project, led by the executive team, involved road shows to consult staff on developments within the trust. Staff gave us examples of developments they had been involved in including reducing the amount of time staff spent on the trusts electronic care record system and reviewing the falls risk assessment process. Staff told us reviewing both processes, would allow them more direct patient care time.

In the national staff survey the trust was only better than average in 5 of 28 areas and in the worst third for 13 out of 28 measures, with staff feeling satisfied with the quality of work and patient care significantly below the national average of 75% at 66%. For the question staff recommendation of the trust as a place to work or receive treatment, the trust were in the worst third of community trusts.

One indicator showed significant improvement since 2012, and there were five areas which deteriorated significantly from 2012.

Public and staff engagement

There was a staff, stakeholder patient and public engagement group as one of the board's assurance groups to seek assurance on stakeholder engagement. We were told how staff engagement has highlighted the areas for improvement in the quality improvement programme. Senior board staff that we interviewed prioritised quality, and this was part of the reason why they had developed the 'time to care', project noted above.

The trust undertook the Family and Friends Test, and whilst response rates were often low, the results were positive. With district and community nurses providing excellent care and showing dignity and respect at all times. The trust has an internal target of 80% positive responses on a 20% sample size. Over 2013/2014, 4 out of 6 reported wards exceeded this target in terms of positive responses, and overall the trust achieved 85.99%. In terms of sample size, no wards achieved the target and overall the trust achieved an average of 12% sample size.

Innovation, improvement and sustainability

There were a range of developments and innovations across the trust; for example the health visiting service had developed a breastfeeding website so parents were able to access support and guidance 24 hours a day seven days a week. This had been launched during breastfeeding week in August 2014.

The tissue viability nurse in the north east business unit was piloting the use of a pressure mapping kit. Patients were asked to sit on the mat without using pressure-relieving equipment. The patient and the staff member then viewed on a screen a map indicating the pressure changes when the equipment was appropriately in place. The nurse was also working with an occupational therapist as this helped improve posture as well as pressure care.

In some areas staff indicated that innovation was less easy to achieve. For example staff at Louth County Hospital felt that innovation and improvements had been difficult to implement due to staffing levels and the impact of the ward environment.