Pilgrim Hospital

Quality Report

Pilgrim Hospital Boston
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall summary

We carried out an unannounced focused inspection of the emergency department at Pilgrim Hospital, Boston on 7 January 2020, in response to concerning information we had received about the care of patients in this department. At the time of our inspection the department was under adverse pressure. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology. We found that:

The department was too small for the number of patients attending. This impacted on how patient flow could be managed. It also resulted in patients being treated in corridors or the central space of the department and having their dignity compromised. The department was not compliant with several standards

Patients who self-presented were triaged in line with national guidance. However, some patients continued to wait considerable time before being clinically assessed and treated.

The service did not have enough permanent nursing or medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment, relying on substantial numbers of bank and agency staff. However, managers continually reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

Some staff did not treat patients with compassion and kindness nor did they respect their privacy and dignity. The crowded nature of the department resulted in some conversations taking place with other patients present.

Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.

Leaders lacked the skills and abilities to run the service. Poor clinical leadership resulted in poor situational awareness when risks within the service increased. Local leaders did not fully understand or manage the priorities and issues the service faced; the continued to not be able to find sustainable long-term solutions.

Summary of findings

The service did not have a specific vision at service level for what it wanted to achieve or a clear strategy to turn it into action, developed with all relevant stakeholders. There were some plans in place which were aligned to local plans within the wider health economy.

The service monitored activity and performance however this was not driving the necessary improvements.

As a result of this inspection, we have identified areas which the trust make take to ensure they comply with relevant elements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 fundamental standards.

Areas 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 hospital MUST take to improve to:

- The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments and within defined timescales. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that consultant and nurse cover in the department meets national guidelines. Regulation 12 (c)
- Fully implement the trust wide actions to reduce overcrowding in the department.12 (2) (a) (b) (i)
- The trust must ensure that the privacy and dignity of patients receiving care and treatment in the emergency department is maintained at all times. 10(1)

Following this inspection, we have taken urgent enforcement action, to impose conditions on the trust's registration to make urgent improvements in the quality and safety of care for patients.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to Pilgrim Hospital

Urgent and emergency services are provided by the trust at three sites across Lincolnshire: Lincoln County Hospital, Pilgrim Hospital, and Grantham and District Hospital.

The emergency departments based at Lincoln County Hospital and Pilgrim Hospital provide consultant-led emergency care and treatment 24 hours a day, seven days a week to people across Lincoln and the North Lincolnshire area. Grantham and District Hospital closes overnight.

(Source: Routine Provider Information Request (RPIR) – Acute context)

Details of emergency departments and other urgent and emergency care services

Lincoln County Hospital

- Accident and emergency department
- Paediatric emergency service
- Ambulatory care bay

Pilgrim Hospital

- Accident and emergency department
- Ambulatory emergency care

Grantham and District Hospital

- Emergency assessment unit
- Assessment and ambulatory care
- Accident and emergency department

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Pilgrim Hospital, Boston is a large district general hospital located on the outskirts of Boston. At Pilgrim hospital, the urgent and emergency services consist of the emergency department (ED) and an Ambulatory Emergency Care (AEC) unit.

The ED has a waiting and reception area, two triage rooms, 10 major cubicles, three minor cubicles, one 'fit to sit' room, a see and treat room, a plaster room, a clean procedure room, four resus bays, three rapid assessment and treatment (RAT) cubicles, one waiting room and a quiet relative's room which was also used as a mental health assessment room.

AEC is open Monday to Friday, 08:30am to 10:30pm and has six beds and two seated areas

Pilgrim Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy, before transfer to the major trauma centre at a neighbouring NHS trust.

Trust activity for the emergency department from September 2018 to August 2019:

- 146,586 A&E attendances (-0.5% change compared to the same time 2017/18)
- 23,727 Children attendances (-8% change compared to the same time 2017/18)
- 52,535 ambulance attendances (+6% change compared to the same time 2017/18)
- 5% patients left without being seen (0% change compared to the same time 2017/18)
- 7.5% re-attendances within 7 days (0% change compared to the same time 2017/18

Trust activity for the preceding 6-weeks to 22 December 2019 was reported as follows:

- 48% of patients are admitted, transferred or discharged within four hours. This is significantly worse than the England average.
- 24-26% of patients were seen by a clinician within 60 minutes.
- On average, between 25 and 40 ambulances a day experienced delays of 60 minutes or more from arrival to handing over their patient to trust staff.
- The number of emergency admissions (referred to as the conversion rate which relates to the number of patients who present to an emergency department and who are subsequently admitted for ongoing care and treatment) was on average 31%.

Inspection and regulatory history

Between December 2012 and July 2019, we have inspected urgent and emergency care services at Pilgrim

Summary of this inspection

Hospital, Boston ten times. We have previously taken urgent enforcement action where we have considered the quality of care and safety of patients was not within expected standards.

Our inspection team

Our inspection team included a CQC inspector and two specialist advisor's consisting of the national professional advisor for urgent and emergency care and a senior nurse whose background was in emergency care.

The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection for Midlands region.

How we carried out this inspection

This was a focused unannounced inspection of the emergency department at Pilgrim Hospital, Boston on 7 January 2020.

We did not inspect the whole core service therefore we have not reported against or rated the effective domain. We did not inspect any other core service or wards at this hospital however we inspected the emergency department at Lincoln County Hospital using the same inspection methodology on 6 January 2020.

During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry however because we took urgent enforcement action, we have rated this service in line with our published policy position.

Inadequate

Urgent and emergency services

Safe	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Summary of findings

The department was too small for the number of patients attending. This impacted on how patient flow could be managed. It also resulted in patients being treated in corridors or the central space of the department and having their dignity compromised. The department was not compliant with several standards

Patients who self-presented were triaged in line with national guidance. However, some patients continued to wait considerable time before being clinically assessed and treated.

The service did not have enough permanent nursing or medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment, relying on substantial numbers of bank and agency staff. However, managers continually reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

Some staff did not treat patients with compassion and kindness nor did they respect their privacy and dignity. The crowded nature of the department resulted in some conversations taking place with other patients present.

Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.

Leaders lacked the skills and abilities to run the service. Poor clinical leadership resulted in poor situational awareness when risks within the service increased. Local leaders did not fully understand or manage the priorities and issues the service faced; the continued to not be able to find sustainable long-term solutions.

There were a range of improvement plans and initiatives to address longstanding challenges across the emergency care pathway. There was however, no defined current vision at service level for what it wanted to achieve or a clear strategy to turn it into action, developed with all relevant stakeholders.

The service monitored activity and performance however this was not driving the necessary improvements.

Inadequate

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

Environment and equipment

The department was too small for the number of patients arriving. This impacted on how patient flow could be managed It also resulted in patients being treated in corridors or the central space of the department and having their dignity compromised. The department was not compliant with several standards.

- On our arrival on 7 January 2020, the hospital was at operational performance escalation level four. 33 patients required admission to hospital having been reviewed by specialty teams. A shortage of hospital in-patient capacity was preventing admissions and these patients were being cared for in the central area of majors, as well as being located in the plaster room, along the main ambulance arrival corridor (three patients), and also nine patients receiving care in chairs located throughout the emergency department. The resuscitation and major's areas were both operating at full capacity as was the integrated assessment centre (IAC). This meant there was extremely limited capacity for patients who required resuscitation, or those patients who required management in an appropriately equipped clinical bed space. Further, the congestion of the department resulted in very limited space to move patients, therefore creating unintended fire hazards. The longest wait in the department was 20 hours and 20 minutes as at 10am on 7 January 2020. Two senior staff spoken with had reported that overnight, four patients had experienced delays of more than four hours from arrival by ambulance to being moved in to the emergency department.
- Overall the department was not compliant with standards recommended by the Psychiatric Liaison Accreditation Network (PLAN), Intercollegiate Committee for Standards for Children and Young People in Emergency Care and Health Building Note 15-01: Accident and Emergency Departments. The department was congested at the time of the inspection. Poor organisational flow resulted in patients being cared for in the central area of the majors department, on trolleys. Staff had worked to limit the number of patients on trolleys in this area. Four patients were being managed continually in this area during the inspection. We had previously found up to six patients were being nursed in this area. Despite the reduction in trolleys, the area did not lend itself to protecting patients privacy and dignity. Patients remained in close proximity to one-another, therefore impacting on the ability for patients to be sufficiently spaced for infection control purposes.
- The resuscitation area operated at full capacity for the duration of the inspection. Department staff worked tirelessly to try and stabilise patients as quickly as possible in order further resuscitation space could be created to meet demand. We noted one case in which a patient was held on an ambulance for over an hour despite the paramedic twice raising their concerns about the patient's deteriorating condition. A clinical space was eventually found in the rapid assessment area however the patient requiring increased care and treatment and was subsequently relocated to a resuscitation bed. Staff caring for the patient were clearly distressed because of the delay the patient had experienced which had likely increased the level of care and treatment the patient required. We further noted a second case in which a patient remained on an ambulance despite having chest pain and having a complex medical history. There was no appropriate monitored bed space for the patient to be relocated too and so hospital staff had been required to commence an assessment of the patient whilst they remained on the ambulance.

Assessing and responding to patient risk

Patients who self-presented were triaged in line with national guidance. However, some patients continued to wait considerable time before being clinically assessed and treated.

- The department had a triage system which was aligned to a nationally recognised triage system. This categorised patients according to a risk rating of one to five. For example, level two was a threat to life which required immediate nurse assessment and to see a doctor within 15 minutes; and level four was a moderate risk, to see a nurse within one hour and a doctor within two hours. After initial registration, patients experienced delays in being seen and treated by a clinical decision maker. We saw five patients arriving by ambulance remained on the ambulance between 20-68 minutes

waiting to enter the department. At 11:30, four patients remained on ambulances including a patient who arrived with chest pain. The patient had a complex medical history and had received three doses of strong pain medicines to help manage their symptoms. The patient received an initial assessment from the pre-hospital practitioner (PHP) whose role it was to oversee the clinical condition of patients who could not be moved immediately in to the emergency department. It was reported the patient had been assessed by the consultant but there was no handwritten contemporaneous record of this. The PHP reported the patient had had an ECG and bloods taken and the consultant had determined it was safe for the patient to remain on the ambulance. The patient was moved in to the department one hour after arrival. It was the professional view of the National Professional Advisor for urgent and emergency care that the patient should, in light of their medical history, been prioritised and moved more quickly in to a monitored bed space for close clinical observation and management. A lack of appropriate clinical space in the department prevented this from happening.

- At 13:00, five patients were on ambulances and two patients in the ambulance corridor. One patient remained on an ambulance with a national early warning score of six. The patient was reported to be septic and had a delay of 20 minutes before being offloaded to trust staff
- A third patient was conveyed by ambulance due to an acute presentation of urinary retention (blocked urinary catheter). It was noted the patient was in severe pain and had been escalated twice by the paramedics to the nurse in charge. The patient was very agitated and was subsequently escalated to the hospital ambulance liaison officer (HALO). The PHP was attempting to create capacity by escalating to the nurse in charge and by transferring patients to the GP streaming service located at ED reception however no member of nursing staff had been to assess the patient. An hour and ten minutes after they first arrived, the patient was called in to rapid assessment and initial treatment (RAIT). An initial assessment of the patient recognised them as being acutely unwell. The patient was quickly moved to resuscitation due to a deteriorating picture. They were reviewed by the ED consultant and a working diagnosis of urosepsis was recorded. The observations for the patient at that time were deranged suggesting the patients condition was deteriorating. Intravenous antibiotics were prescribed at 14:04; but not administered until 14:34. This was approximately two hours after arrival; Oxygen was not prescribed nor administered despite pulse oximetry of 90%. The management of this patient was contradictory to the national sepsis six care bundle. A similar incident was reported on 16 August 2019 when a patient presented with frank haematuria (fresh blood present in the urine). The patient's national early warning score was recorded as seven. No sepsis screen had been completed. The patient was treated for a very low blood pressure and shock due to significant blood loss. The ED team had not considered sepsis despite the surgical team noting possible septic shock presentation.
- During the inspection we reviewed 15 sets of patient records. We noted one patient had arrived by ambulance and was triaged as a category two patient. A medical review of the patient was carried out at at which point a focal infection was considered. The medical notes made no reference to sepsis despite the presentation. Intravenous fluids were prescribed and to be administered over four hours. The NEWS for the patient was seven. At 14:00, the patient was transferred to the resuscitation area and intravenous antibiotics were administered approximately three hours after the patient arrived. An intensive care review was completed at which point it was suggested the ED team commenced management of hyperkalaemia (a high potassium level which can lead to heart arrythmia's and other life threatening symptoms); appropriate fluid resuscitation and appropriate management of hypoglycaemia. These recommendations suggested the ED team had initially failed to fully assess and actively treat the deranged values recorded on the blood samples taken from the patient when they first arrived in to the department. Prior to the inspection we reviewed all incidents reported by the department between June 2019 and December 2019. We noted one case reported at the trusts other emergency department in November 2019 whereby a patient arrived to the ED. The patient was examined by a doctor and was to commence on the hyperkalaemia pathway which had been prescribed by a foundation grade doctor. The initial stage of treatment had been commenced however it was reported no further intervention had commenced prior to the patient being transferred to the Medical Emergency

Assessment Unit at 17:00. At 18:35 it was reported the patient deteriorated and died. These incidents suggested a lack of learning across the organisation and continued to present a risk to patients.

- On 6 January 2019 a patient presented with fever and nausea. It was noted in their notes they were a type two diabetic. Urosepsis was considered at 01:33 due to an increasing NEWS score as a consequence of deterioration in the patients condition. Antibiotics were prescribed at 02:37am. During the post take ward round, the medical consultant requested routine monitoring of blood glucose levels due the patient having a history of type two diabetes; this diagnosis was known to nursing staff as a note had been made on the patients paper attendance record at the triage stage. We noted that only one blood glucose level had been recorded as at 11:00 when notes were reviewed. We have previously raised concerns over the management of patients with diabetes across the emergency departments at Pilgrim Hospital and the trust's other emergency department at Lincoln County Hospital. We further note STEIS reference 2019/10581 which relates to the management of patients in diabetic ketoacidosis. We found that changes to practice had been introduced at Lincoln County hospital during our inspection of that emergency department on 6 January 2019. These changes included the diagnosis of diabetes being visible on the trusts patient information system, so as to alert staff. However, this was not the case at Pilgrims Hospital. We therefore have concluded there remains a lack of embedded learning following serious incidents.
- A pre-alerted patient was conveyed by ambulance and arrived at 20:32. The patient was triaged but was not clinically assessed until 03:02. The working diagnosis was sepsis and so intravenous fluids and antibiotics were commenced. These were administered at 04:14, therefore meaning the patient was not exposed to timely clinical management.
- On 01/01/2020 a patient having recently had chemotherapy within the previous six weeks, presented with neutropenic sepsis. The patient arrived at 09:20 and it was assuring to note a sepsis bundle had commenced at 09.25. However, antibiotics were not administered until 10:45, resulting in the patient falling outside the one-hour golden window. Management of neutropenic septic patients remains an area which requires significant improvement. A review of NRLS identified 23 failed door to needle neutropenic septic patients between July and December 2019 suggesting a lack of embedded or sustained improvement.
- We noted a serious incident report which reported a patient presented with a two-day history of chest pain, shortness of breath and nausea. The patient was diagnosed as suffering gastritis. The patient remained in the emergency department until they were transferred to the integrated assessment centre. A senior clinical review at requested additional clinical interventions including an ECG blood samples. There was a delay in the results of these tests being shown to a senior clinical decision maker. The patient was subsequently escalated, and staff instigated the acute coronary syndrome pathway. The patient was referred to the cardiac catheter laboratory at Lincoln County however the patient subsequently died awaiting treatment. We were told during the inspection that learning from the serious incident included ensuring all patients presenting with chest pain would receive an ECG within ten minutes of arrival. During the inspection we noted a patient presented with chest pain. An ECG was not carried out for approximately 30 minutes at which time the patient was moved to the resuscitation room for rapid consultant review then timely transfer to coronary care unit on-going management. On 05/01/2020 a patient presented with chest pain. The first recorded ECG in the notes was not carried out until for approximately two hours after the patient first arrived. We therefore concluded there remained a lack of embedded or sustained improvement or robust learning from this serious incident as staff were not following the revised guidance of completing an ECG within ten minutes for all patients presenting with chest pain. This therefore meant there is a residual risk to patients who may present with such symptoms.

Nursing staffing

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment relying on substantial numbers of bank and agency staff. However, managers continually reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

- The number of nurses and healthcare assistants on all shifts in each clinical area did not always match the planned numbers. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. However, in order to do this, they needed to make use of significant numbers of bank and agency staff.
- We reviewed a range of rotas dating from 8 November to 6 January 2020. We were informed by the lead nurse that following a review, there had been a reduction in the number of nurses deployed during both day and night shifts, which took effect from 6 January 2020. This meant 11 nurses and six healthcare assistants were rostered to support the department as compared to the historic 12 nurses and six healthcare assistants.
- The department had a combined vacancy rate of 63% across the nursing workforce. This meant that on every shift we reviewed, the department relied on agency staff to support them and ranged from one agency nurse on a shift through to eight agency nurses. Senior nursing staff reported the challenges of trying to complete a rota which was sufficiently staffed with people who had the right skills and experience to ensure the department remained safe. It was recognised by the local leadership team that shortage of substantive staff and appropriate skill mix generated an inherent risk in the department, for which there remained no long-term solution. The matron had amended the recruitment campaign to ensure that any prospective employee could be deployed across any of the hospital sites within the group, as compared to recruiting individuals to an individual location only.
- The service did not meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children's nurses on each shift. The trust recognised this as an area for improvement and had worked with practitioners from neighbouring trusts to up-skill and improve the competency of nurses allocated to care for children. There was one paediatric trained nurse on duty 24 hours a day who operated from a single cubicle which was located in the adults majors area. . There was a separate paediatric waiting room however this was isolated from the rest of the department. This meant staff could not directly observe the area and therefore meant any child at risk of deterioration whilst in the waiting room may not have been recognised.

Medical staffing

The service did not have enough permanently employed medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed staffing levels and skill mix, recruited sufficient locum doctors and gave those locum staff a full induction.

- There were eight whole time equivalent consultants in the department; only one consultant was substantive and was the only one on the general medical council specialist register. Other consultants were in the process of preparing for the certificate of eligibility for specialist registration (CESR) (a GMC initiative which supports doctors to register as a consultant, first having joined a specialist registrar, when individuals have either trained in non-approved posts or they have entered an approved training post at a later starting point and completed the rest of the programme and gained the remaining competencies). A number of doctors had competed a limited number of components of the Fellow of Royal College of Emergency Medicine exam to enable them to join the specialist register.
- There was no designated consultant who was registered as a specialist paediatric emergency medicine consultant. This was despite the department seeing around 10,000 children per year and was listed as a key requirement in the Royal College of Paediatrics and Child Health: Facing the Future - children and young people in emergency care settings.
- Consultants were present in the department from 08:00 hours to 21:00 hours Monday to Friday and between 09:00 and 21:00 at the weekends.
- Middle grade cover included five trust grade doctors. The rota was mainly covered by agency locums. This was recognised as a major concern by the local team because they considered there were not enough senior doctors present to manage seriously ill patients and to also supervise junior doctors. A lack of substantive consultants to support junior doctors was recognised as

a factor for the department not being able to accept junior trainee doctors and therefore further hindered the trusts ability to recruit sufficient doctors to meet the needs of the population.

- We spoke with five junior doctors during the inspection. They each reported they received appropriate supervision from more senior doctors and were complimentary about the teaching sessions which were held weekly. However, individual doctors told us they felt the lack of capacity in the department contributed to delays in being able to see and assess patients. Some doctors reported they would recommend the department to other junior doctors as a good place to work, whilst others reported they would not recommend it to more junior doctors due to the high intensity of the work load.

Are urgent and emergency services caring?

Inadequate

Compassionate care

Some staff did not treat patients with compassion and kindness nor did they respect their privacy and dignity. The crowded nature of the department resulted in some conversations taking place with other patients present. The individual needs of patients was not always considered or acted upon. Staff did not always provide appropriate emotional support to patients.

- Due to the congested and crowded nature of the department, a large proportion of patients were receiving care in non-clinical areas including the central bay of the major's area or in corridor's. We observed on multiple occasions when staff failed to support patients in protecting their privacy. We observed the matron worked hard to ensure frail elderly patients were covered however this was not sustainable, resulting in some patients falling in to a state of undress.
- We spoke to nine patients and their relatives during our inspection of the emergency department. Four patients were confused as to what was happening; they were not aware of their clinical treatment plans despite having been in the department for extended periods of time. There was a general consensus from patients the environment was not fit for purpose and offered no privacy. Long waiting times and a lack of space for relatives to sit was also reported as a frustration by those using the service. We noted occasions when elderly relatives were having to stand by beds or occupied chairs because a lack of space in the department meant there was no space for additional seats to be found. One patient who was nauseous and at times actively vomiting was held in the central area of the ED due to a lack of cubicle spaces. One elderly patient remained on a trolley for the duration of our inspection. The patient was located by a door and had very little input from nursing staff for the duration of their stay. Despite being located by a door which was frequently used, the patient was only afforded one blanket despite it being a cold day. Nursing staff had not considered the holistic needs of the patient.
- The percentage of patients who would recommend urgent and emergency care services has consistently been worse than the national average since July 2017.
- We had previously reported concerns with how well the nursing leadership of the department managed other health professionals during times of increased departmental activity. We had previously seen on an inspection an altercation between the nurse-in-charge and a paramedic who was concerned about the care of their patient, who in the opinion of the paramedic, required rapid treatment. At this inspection we observed a senior paramedic twice escalate concerns over the condition of their patient who remained on an ambulance. Despite the paramedic having given the patient morphine to manage their pain, the nurse-in-charge was dismissive of the paramedic's concerns and did not afford sufficient priority to meet the needs of the patient who had underlying neurological deficit and so was at increased risk of distress.
- Patients told us they had been treated well and with kindness. When we observed care and treatment being given we noted this almost always to be the case. We observed that, at times, staff did not always give patients and/or their relatives support to cope emotionally with their care, treatment or condition. We observed the time staff spent with patients was limited because they were busy. This resulted in staff adopting a task-orientated approach to providing care as compared to providing holistic patient centered care. We noted on one occasion, a patient who was clearly distressed and

disorientated, being cared for in the central area. Nursing staff did not stop to consider emotional needs of the patient, nor did they provide any assurances to the patient.

- The crowded nature of the department resulted in some conversations taking place with other patients present. This was particularly noted for those patients receiving care in the corridor, main bay and the seated area within majors.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Inadequate

Access and flow

Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.

- Front line staff reported they were on operational pressure escalation level (OPEL) four at the time of the inspection. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care.
- NHS Trusts are required to monitor and report nationally the percentage of patients who attend ED and get seen, discharged or admitted within four hours of arrival. This is known as the Emergency Access Standard (EAS). The NHS standard requires 95% of patients to spend less than four hours in ED. Lincoln County Hospital has consistently not met this target in any month between January 2019 and December 2019. On the day of the inspection, performance against the access target was reported to be 59.7% as at 13:45. 53 patients were in the department and eight patients had a decision to admit but no bed was available for them to be transferred too.
- There was evidence that the lack of flow had a direct negative impact on patient safety, quality of care, privacy, dignity and confidentiality. Some patients had been managed on the corridor for the entirety of the time there. Many of these patients were elderly and could be anticipated that they may have reduced mobility and additional care needs. Due to lack of space in the corridor there were many patients on trolleys rather than on beds. The environment was inappropriate to meet patients care needs for extended lengths of time such as feeding, toileting, mobilising and sleeping. Patients reported that due to the noise, light and activity in the majors and corridor, they had been unable to rest comfortably.

Median time from arrival to treatment (all patients)

- Managers monitored waiting times and tried to make sure patients could access emergency services when needed and received treatment within agreed time-frames and national targets.The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard and was much worse than the England average from November 2018 to October 2019. The median time to treatment on the day of inspection was approximately 26%.

Percentage of patients waiting more than 12 hours from the decision to admit until being admitted

- Over the 12 months from December 2018 to November 2019, 12 patients waited more than 12 hours from the decision to admit until being admitted.The trust reported 0 patients in all months apart from March (one patient)and November 2019 (11 patients).

Percentage of patients waiting more than four hours from the decision to admit until being admitted

- From December 2018 to November 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

Inadequate

Urgent and emergency services

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

- From November 2018 to October 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average.

- The resulting fact of poor departmental flow was patients experiencing extended stays in the department. Staff reported they could not accept new patients who arrived by ambulance. We observed this to be the case during the inspection. This resulted in patients having to wait on ambulances until there was sufficient space in the department for the patient to be clinically assessed and their care and treatment commencing.
- We observed patients being cared for on trolleys throughout the department and have discussed this further in the safe domain. The executive team recognised the management of patients on trolleys for extended periods was far from optimal in that patients could not get comfortable and nursing staff could not provide consistent pressure area care due to the limited surface area of the trolley, allowing for regular repositioning of patients.
- Patients were provided with blankets and pillows however due to the high level of foot traffic, and general noise levels, patients who required admission to a hospital bed found it difficult to rest.

Are urgent and emergency services well-led?

Inadequate

Leadership and culture

Leaders lacked the skills and abilities to run the service. Poor clinical leadership resulted in poor situational awareness when risks within the service increased. Local leaders did not fully understand or manage the priorities and issues the service faced; they continued to not be able to find sustainable long-term solutions.

- We had previously reported that appropriate arrangements had not been made to address the risks presented by gaps in clinical leadership capacity. At the time the existing clinical lead was scheduled to take extended planned leave, the trust executive team had approached existing ED consultants to seek a lead to cover the trust wide emergency clinical lead role. However, no-one volunteered to accept the role. and so arrangements were made for two individuals to adopt local, hospital based leadership instead. This resulted in the being no over-arching clinical leadership of emergency care services within the trust.
  - The trust board had opted to streamline the organisational structure. However, despite both internal and external recruitment campaigns, the trust had experienced difficulties in recruiting a substantive divisional director to oversee and lead the medicine and urgent care division. This created further risks in the governance and oversight of the service.

- The emergency physician in charge (EPIC) role was not consistently fully effective and was an area we had previously reported as requiring significant improvement. The aim of the role was to provide overall senior clinical responsibility for the emergency department in line with Royal College of Emergency Medicine guidance between 08:00 and 24:00. The role was intended to ensure safe and effective care, appropriate escalation and achievement of performance standards. This was not happening when we inspected. The EPIC lacked any situational awareness as to the increasing occupancy and associated risks of the emergency department. There was a lack of cohesive working between the nurse in charge and the EPIC which further suggested risks were not being effectively managed. This was acknowledged as an area for improvement by the trust executive team.

Vision and strategy for this service

The service did not have a specific vision at service level for what it wanted to achieve or a clear strategy to turn it into action, developed with all relevant stakeholders.There were some plans which were aligned to local plans within the wider health economy.

- We had previously reported the trust had a vision and a set of values stated in 'Shaping our future for 2021 and beyond.'
- The trust had a programme management approach to develop urgent care across the trust which dovetailed with local system partner's arrangements. However, staff

were not clear on what the strategy was, other than the need to recruit doctors and nurses. The trust had received capital funding from government-led initiatives for the development of the emergency department at Pilgrims Hospital, Boston. A business case to secure the funds was scheduled to be submitted in March 2020. However, the trust reported that current HM Treasury requirements meant there would be significant delays between each stage of the application process, therefore resulting in a final ED build occurring around quarter four of 2020/2021. There remained no costed strategy at site level which combined quality and safety improvement.

- There was significant focus being placed on the new build. During the inspection, we were informed the acting clinical lead had been appointed substantively as the local clinical lead, reporting direct to the trust-wide lead for urgent and emergency care. Their vision was to address the "Back-door" challenges of the department. Despite us probing workforce challenges, sustainable change programmes, quality, and safety, the clinical lead did not specifically recognise these as priority areas. It was considered the clinical lead was orientated on generating capacity in the department which would lead to improvements in patient experience, quality and safety, but without considering the actions required to be taken with the emergency department itself, including the development of clinical leaders for example.
- Some plans partially addressed issues. A new divisional workforce plan had delivered improvements in reducing the nurse vacancy rate at Lincoln County Hospital however there remained an extensive nurse vacancy rate at Pilgrim Hospital, Boston. The lack of a trust-wide clinical lead and the challenges in appointing to the divisional director role had likely impacted on the pace of change within the service. The trust reported there was an ED improvement plan as part of the Urgent Care Improvement Plan, which addressed the vision and direction of travel for the department. This plan integrated with other system partners to consider actions required across the system to reduce attendances, reduce conveyances, and improve handover. However, a lack of strategic planning which delivered identifiable outcomes in a sustainable and meaningful way which considered risks across the whole emergency care pathway through Lincolnshire had resulted in inequity in how the workforce was deployed, thus generating increased risk and poor patient experience and quality of services at one site over another. The trust reported there was however, a revised and agreed nursing workforce plan which considered a trust-wide recruitment plan that focused on both domestic and international recruitment. There was a focused work plan agreed with local universities and Health Education England to improve the knowledge and skills of staff caring for children and young people. This also included offering training to existing nurses to obtain a 2nd registration of child branch.

Governance, risk management and quality measurement

The service monitored activity and performance however this was not driving the necessary improvements.

- Data relating to performance was clearly displayed in the unit. Staff openly discussed performance and what it meant for patients. Whilst new models of care and nursing assessments had been devised in an attempt to manage the safety of the department, there was a lack of awareness or consideration given to national quality standards. Further, there seemed little understanding or robust solutions to tackle concerns which had existed for a number of years and for which we have consistently reported areas requiring improvement. We had seen little or no improvements in some cases, including nurse recruitment, patient flow and respecting the privacy and dignity of patients.
- The lack of trust-wide leadership may have contributed to the lack of systematic improvements being made following incidents. For example, we reported a lack of learning from incidents which had occurred at Lincoln County Hospital, but which were applicable to the delivery of care at Pilgrim Hospital, Boston. Staff working at Pilgrim Hospital were not aware of serious incidents which had occurred in other services, nor those incidents which had taken place at Lincoln County Hospital. Where lessons had been learnt from previous incidents, there was a lack of sustained improvement. For example, staff were failing to undertake ECGs within ten minutes for patients who presented with chest pain as observed during the inspection and from having reviewed patient notes. We further noted a lack of embedded change in relation to the management of

patients who presented with conditions such as hyperkalaemia or hypoglycaemia despite there having been previous serious incidents resulting in harm or death.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
Action the hospital MUST take to improve to:

- The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments and within defined timescales. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that consultant and nurse cover in the department meets national guidelines. Regulation 12 (c)
- Fully implement the trust wide actions to reduce overcrowding in the department.12 (2) (a) (b) (i)
- The trust must ensure that the privacy and dignity of patients receiving care and treatment in the emergency department is maintained at all times. 10(1)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. 1. The provider should ensure that patients who present to the emergency department commence active treatment within a defined period of time as set out on the Providers Certificate of Registration. 2. The registered provider must ensure that there are systems in place across the emergency department at Pilgrim Hospital Boston so that patients are assessed and cared for in the area appropriate for their acuity at all times. 3. The registered provider must ensure that the systems make provision for effective monitoring of the service user's pathway through the emergency department at Pilgrims Hospital Boston. 4. The registered provider must ensure there are appropriate systems in place to monitor the condition and risk of deterioration for all patients awaiting admission (e.g. on ambulances or in corridor areas awaiting triage) to the emergency department at Pilgrims Hospital Boston. 5. The registered provider must ensure that appropriate emergency department escalation procedures are maintained and followed by all staff including at times of peak capacity and demand at Pilgrim Hospital Boston.

This section is primarily information for the provider

Enforcement actions

6. The registered provider must ensure that at all times, there is sufficient capacity in the emergency department to accommodate all patients at risk of deterioration or who require time critical care and treatment; this must be provided in an appropriate clinical setting.

9. The registered provider must ensure the privacy and dignity of patients receiving care and treatment in the emergency department is protected at all times.