Lincoln County Hospital

Quality Report

Greetwell Road
Lincoln
Lincolnshire
LN2 5QY
Tel:01522 512512
Website: www.ulh.nhs.uk

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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 Lincoln County Hospital on 6 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:

- Ambulance handover delays remained a challenge, with some patients experiencing delays of more than 100 minutes from arrival by ambulance to being handed over to trust staff for commencement of care and treatment. Whilst the trust had procedures in place for assessing patients who could not be handed over within 15 minutes from arrival, staff were not consistently following these procedures; further, the trust had a lack of robust assurance and oversight for ensuring such procedures were consistently followed.
- Patients did not always see a senior clinical decision maker within nationally defined timescales resulting in delays in them starting their treatment.
- Patients could not always access the service when they needed to due to overcrowding.
- The service continued to lack a specific local vision to address longstanding issues including the provision of services for children.
- Patients remained on assessment trolleys for extended periods of time. The trust reported the number of patients who sustained pressure damage however there was not an effective means of addressing this. We raised this as an area of concern with the trust and asked them to take remedial action to address this.

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.

Summary of findings

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 on appropriate beds. 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)

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Contents

Summary of this inspection

Background to Lincoln County Hospital

Lincoln County Hospital is a type one emergency department based in the city of Lincoln. The hospital is a designated major trauma unit; this means patients sustaining major trauma injuries through road traffic incidents or other similar modes of injury can be stabalised, and in some cases treated at Lincoln County Hospital, or alternatively, transferred to a major trauma centre.

The department includes:

- 15 major's cubicles
- Three minor's cubicles
- Four resuscitation bays
- Five rapid assessment and treatment beds

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 April 2014 and July 2019, we have inspected urgent and emergency care services at Lincoln County Hospital four 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.

This inspection was attended by the Chief Inspector of Hospitals, Professor Edward Baker.

How we carried out this inspection

This was a focused unannounced inspection of the emergency department at Lincoln County Hospital Hospital on 6 January 2020.

We did not inspect the whole core service therefore we have not reported against, or rated the effective or caring domains. We did not inspect any other core service or wards at this hospital however we inspected the emergency department at Pilgrim Hospital, Boston using the same inspection methodology on 7 January 2020.

Summary of this inspection

During this inspection we inspected using our focused inspection methodology. Because we issued requirement notices, we rated this service. In line with previous ratings, we rated the safe, responsive and well-led domains as inadequate.

Inadequate

Urgent and emergency services

Safe	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Summary of findings

We carried out an unannounced focused inspection of the emergency department at Lincoln County Hospital on 6 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 design and layout of the emergency department did not consistently keep people safe.
- Ambulance handover delays remained a challenge, with some patients experiencing delays of more than 100 minutes from arrival by ambulance to being handed over to trust staff for commencement of care and treatment. Whilst the trust had procedures in place for assessing patients who could not be handed over within 15 minutes from arrival, staff were not consistently following these procedures; further, the trust had a lack of robust assurance and oversight for ensuring such procedures were consistently followed.
- Patients did not always see a senior clinical decision maker within nationally defined timescales resulting in delays in them starting their treatment.
- Patients could not always access the service when they needed to due to overcrowding.
- The service continued to lack a specific local vision to address longstanding issues including the provision of services for children.
- Patients remained on assessment trolleys for extended periods of time. The trust reported the number of patients who sustained pressure damage

however there was not an effective means of addressing this. We raised this as an area of concern with the trust and asked them to take remedial action to address this.

Inadequate

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

Environment and equipment

The design, maintenance and use of facilities and premises did not consistently keep people safe.

- We previously reported some facilities did not meet Royal College of Paediatrics and Child Health (RCPCH) standards for children. The trust previously reported they did not see enough children to comply with these standards. However, the most current guidance, "Facing the future: standards for children in emergency care settings" no longer differentiates department activity versus compliance with the standards. Instead, current guidance recommends that all providers who see and treat children and young people should strive to meet the national standards in order to enhance the quality and safety of services.
- At this inspection, a waiting area had been created to accommodate children who were waiting to be seen. Although efforts had been made to identify a space which was audio-visually separate from the main adult waiting room, the allocated space was not appropriate in that immediately outside the room, seating allocated for parents and carers was routinely used by adults waiting to be seen. A stud wall had been erected as a means of trying prevent adults waiting from having direct line of sight to the children's waiting area. However, we noted this blocked the line of sight for clinical staff and therefore introduced additional risk in that staff did not have capacity to view children and to identify a patient at risk of deterioration. Whilst we observed adults using the area directly outside the children's waiting room, departmental staff further reported that patients conveyed to the department by police, and individuals in police custody, or those residing at the local prison, would sit in the area directly outside the waiting room. Although not witnessed, we concluded there was a risk infants, children and young people could be required to share waiting areas with patients who were aggressive, violent, or those who were distressed. This was contradictory to national best standards. The provision of services for children and young people was recognised as a significant challenge for the organisation. However, there remained no formalised strategy or long term plan for resolving the issue, in part because of a lack of space in the emergency department to create a dedicated area.
- During the inspection, there was sufficient space to accommodate patients. Patients arriving by ambulance were handed over with no delay; patients were cared for in cubicles or other appropriately designated clinical areas. However, data suggested there remained a lack of sufficient capacity across the hospital to meet local needs during times of peak activity. On our arrival at approximately 12:30, there were 41 patients in the department; eight patients were awaiting an inpatient bed with the longest wait recorded as 16 hours. During the week leading up to Christmas 2019, national data reported the number of patients arriving by ambulance who experienced delays of 60 minutes or more before being handed to trust staff ranged from 25 to 40 patients per day. United Lincolnshire Hospitals NHS Trust was reported as the worst performing trust during this time period. National standards set by the Royal College of Emergency medicine We were informed that during times of peak activity, if there was insufficient capacity in the department for patients to be handed over, patients would be held on ambulances until such time that patients could be transferred in to the emergency department. We were told there was a new system by which trust nursing staff would continue to clinically assess patients on ambulances, within 15 minutes to ensure it was appropriate for them to remain on the ambulance; where staff identified a patients as requiring time critical care or treatment, these patients would be transferred directly in to the emergency department. Because there was sufficient capacity to enable staff to offload ambulances quickly, on 6 January, we could not assess the effectiveness of this new process. However, we heard via the trust bed meeting at 16:00 on 7 January 2020 that patients were being delayed in being transferred in to the department, with one patient waiting 109 minutes on an ambulance. It was further reported during the bed meeting that due to poor communication, staff working in the ED were not clinically assessing those patients being held on ambulances. This was contrary to the new revised standard operating procedure and therefore meant the trust executive team could not be assured all patients were being clinically assessed within 15 minutes.

- Prior to the inspection we reviewed all clinical incidents relating to urgent and emergency care services across United Lincolnshire Hospitals NHS Trust for the period of 1 June 2019 to 1 December 2019. We noted a number of incidents related to staff from other departments reporting patients being admitted to wards from the emergency department (ED) with grade two pressure ulcers which had not previously been recognised, therefore potentially meaning the damage was caused whilst patients were in the ED. Tissue viability was an area which we had previously raised concerns about and had issued the trust with regulatory actions requiring them to make improvements. Although this action was directed towards standards of care at Pilgrim Hospital, Boston, due to a divisional structure adopted by the organisation, we would have expected standard actions to have been taken across both emergency departments. We noted that all patients in the department were being nursed on trolleys. We discussed the increase in potential department acquired grade two pressure ulcers with staff. They reported that due to a lack of space in the department, and a lack of bed frames across the organisation, it was necessary to care for patients on trolleys. Staff described action being taken to address the issue, including the availability of pressure relieving equipment such as air mattresses. We raised this with the interim director of nursing who reported the trolleys had been equipped with mattresses designed for patients at risk or very high risk of pressure damage. A review of the mattress specification suggested the mattresses were only suitable for patients "Waiting for treatment" as compared to being kept on the mattress for extended periods of time. We observed frail elderly patients remaining on trolleys for extended periods of time, therefore pre-disposing those individuals to the risk of harm due to not being nursed on an appropriate bed. Whilst we observed some patients being nursed on trolleys being provided with supplementary pressure relieving devices such as air mattresses there were occasions when this did not happen. In one case, an elderly patient who had been identified as being at high risk of skin damage had been on a trolley for six hours and had not been placed on an air mattress or other pressure relieving device. The lack of action by nursing staff could have predisposed the patient to what could have been avoidable harm. This was despite CQC having previously raised concerns, and for which the trust had adopted an action plan. We considered there had been limited overall improvement in this area, for which concerns had existed since 2018.
- We checked a range of specialist equipment, including adult and children's resuscitation equipment. Equipment was clean and organised, and a review of equipment checklists showed that daily checks had routinely completed.Clinical waste was segregated and stored appropriately.

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. Improvements had been made since our last inspection which ensured streaming and triage processes for patients who self-presented to the department. Previous processes involved employees from both a community provider who was commissioned to provide urgent care services, and a nurse from Lincolnshire Hospitals NHS Trust. A member of the community trust was now located at the main reception and was trained to direct patients to the most relevant clinical pathway which was either via urgent care services; the majors department or direct to the resuscitation room if necessary. A new triage area had been created specifically for a trained nurse to clinically assess children who presented and who had been streamed to be seen in the majors area. Adults were seen by a trained triage nurse who was further supported by a healthcare assistant or associate nurse. Basic interventions including ECGs and blood tests could be carried out by the triage team if the patients condition warranted such intervention. We observed patients being called through to the triage team in a timely fashion. Staff took basic medical histories and undertook physical observations including blood pressure, heart rate, neurological observations where

appropriate and physical examinations for patients presenting with minor injuries. We observed nursing staff giving appropriate consideration to the emotional well-being of patients during the triage process, as well as considering safeguarding concerns with one good example or appropriate escalation being observed during the inspection.

- We reviewed 16 sets of patients records. There were examples when patients waited periods of three hours before a triage assessment was completed when arriving by ambulance. This included one patient who was listed as a category two patient and should have therefore been seen by a nurse immediately and then by a doctor within 15 minutes. The patient arrived in to the department at 12:46 but was not triaged until 15:49; the patient was subsequently seen by a doctor at 17:00, some four hours after they first arrived. A second patient arrived at approximately 10am but was not triaged until 11:15. Although the patient was subsequently seen by a doctor at 11:40 and a diagnosis of possible sepsis was considered, antibiotics were not commenced until 13:49. The trust recognised that further work was required to ensure patients were assessed in a timely way and that treatment was commenced according to the clinical needs of the patient. The trust reported an improving picture in relation to the timely commencement of assessment of sepsis with 91.1% of adults and 90.1% of children having a sepsis screen completed within one hour of arrival.
- A review of incidents suggested there remained challenges with ensuring patients who presented with a condition referred to as neutropenic sepsis were managed in accordance with national and local best practice standards. Incident investigations suggested clinical and nursing staff were not routinely considering "Red flag" conditions such as patients who had had chemotherapy in the last six weeks; patients with haematological or oncological malignancies; patients who had previously had stem cell therapy or patients with chronic neutropenia. The departments neutropenic sepsis pathway remained in draft format; staff we spoke with were not all familiar with the pathway and senior staff recognised further work was required to ensure this specific patient cohort were treated in accordance with local protocols.
- Standards set by the Royal College of Emergency Medicine states initial clinical assessment should take place within 15 minutes of arrival. Trust board papers report varied performance against this metric:
  - August 2019 - 82.5% of patients were triaged within 15 minutes
  - September 2019 - 75.2%
  - October 2019 - 82.3%
  - Overall year to date performance (to October 2019) was reported as 79.3%
- As a result of the inspection of the urgent and emergency care service in June 2019, the Care Quality Commission imposed conditions on the providers registration requiring them to ensure that all children were clinically assessed within 15 minutes. As part of the action taken, the trust was required to report routinely, department performance against this standard. The trust reported that for the weeks commencing 18 and 25 December 2019 respectively, 70.8% and 80% of children and young people who arrived by ambulance were clinically assessed within 15 minutes. For the same time period, 61.5% and 78.4% of children and young people who self-presented (or accompanied by a parent/carer) were clinically assessed within 15 minutes. This was reported to be an improving position however staff recognised further work was required to ensure the trust complied with regulatory requirements and met national best practice standards.
- The trust undertook a joint initiative with the local ambulance trust to improve overall ambulance handover performance in order to initially eradicate patients waiting more than 120 minutes from arrival to being handed over. Despite a range of initiatives, the trust had failed to achieve this target as of 22 December 2019. The trust reported the following data-set for performance against the 15 minute handover target for Lincoln County Hospital:
  - October 2019 - 24.7% and 8.2% of patients arriving by ambulance experienced delays of more than 60 minutes and 120 minutes respectively.
  - November 2019 - 22% and 6.3% of patients arriving by ambulance experienced delays of more than 60 minutes and 120 minutes respectively.
  - December 2019 - 27.6% and 10.1% of patients arriving by ambulance experienced delays of more than 60 minutes and 120 minutes respectively.
- Senior staff recognised the importance of supporting ambulances to handover their patients quickly in order

they could return to service to support other patients in need in the community. It was reported a new process had been introduced, with a standard operating procedure being developed in partnership with the trust and local ambulance service which would ensure that any patient delayed in being handed over would be clinically assessed within 15 minutes. This was to ensure the doctors and nurses responsible for the department would be aware of who was waiting and to help identify any patient requiring time critical care and treatment. Because the department was able to offload all patients arriving by ambulance in a timely way during the inspection, we were not able to assess the effectiveness of this new process. However, whilst we were inspecting the ED at Pilgrim Hospital on 7 January 2020, we opted to attend a trust-wide bed meeting. At this meeting it was reported the ED at Lincoln County Hospital was under immense pressure and four ambulances had been delayed by up to 109 minutes resulting in patients being held on ambulances. It was further reported at the 7 January bed meeting that due to a communication error, nursing staff had not been clinically assessing patients who were being held on ambulances. This meant there was a reliance on ambulance trust staff recognising and escalating any deteriorating patient. Local senior nurses had recognised the lack of clinical assessment and reiterated the revised standard operating procedure to ensure all patients were clinically assessed within 15 minutes.

- The national early warning score (NEWS2) system and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). NEWS2 is a point system implemented to standardise the approach to detecting deterioration in patients' clinical condition. We looked at 16 electronic NEWS/PEWS records and saw that they were completed correctly and within defined time frames. A patient information screen located in the department had the most current NEWS score clearly viewable to all staff. This acted as a prompt for staff; colour coding of NEWS scores meant staff could quickly see who the sickest patients were, determined by their NEWS score. Where a patient had a high NEWS score, the screen was locked when the next set of observations were due; this again acted as a prompt for a staff member to reassess the clinical condition of the sickest patients.

Nursing staffing

The service did not have enough 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. However, managers continually reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

- The ED used a combination of the baseline emergency staffing tool and national emergency department staffing recommendations, to ensure the department was staffed appropriately. This outlined how many registered nurses were needed to safely staff the department. The tools looked at the acuity of patients and how many were in the department at certain times of the day. In response to previous concerns raised by CQC in regards to the management of sick children, new competencies and assessment frameworks had been introduced for nurses responsible for caring for children. A competent nurse was scheduled to work on each shift and records confirmed this was happening. Registered children's nurses were employed by the department however, as is similar with the national position, there were only limited numbers employed. As a result, only those nurses who had completed the competency and assessment frameworks, and who had completed additional life support training, were rostered to cover the children's service
- The ED was staffed with 12 registered nurses and five healthcare assistants during the day and three healthcare assistants at night. One healthcare assistant was rostered to support the twilight period in order there were sufficient staff available during peak times. We reviewed rota's dating from 4 November 2019 through to 5 January 2020. On two days, the number of registered nurses available was lower than the number required however there had been an increase in the number of health care assistants deployed. There remained a heavy reliance on agency staff to support the rotas, in part because the department had five whole time equivalent vacancies for band five nurses and two vacancies for band six nurses. Staff reported

changes to clinical roles including that of the clinical co-ordinator and flow co-ordinator. It was reported these roles had historically worked independently of one another, however the department matron who had been seconded to the role, considered it was more appropriate for one senior nurse to assume overall responsibility for the department each shift. As a result, 5.49 whole time equivalent band seven roles had been approved and were actively being recruited to at the time of the inspection.

Medical staffing

The service did not have enough 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.

- On commencement of the inspection at approximately 12:30. the department was being managed and clinically led by an experienced consultant. There was appropriate numbers of doctors available to see and treat patients in a timely way. However, we noted that following a change to the consultant in charge, flow through the department started to slow down. The time patients waited to be seen and treated by a senior decision maker started to increase and there was little situational awareness from the consultant-in-charge and nurse-in-charge (flow co-ordinator) to address this. This resulted in patients waiting extended periods of time before their treatment started. At approximately 13:45 it was reported the number of patients who were seen and a plan of care prescribed by a senior decision maker within 60 minutes was 26%. We raised this with the executive team who acknowledged significant work was required to ensure clinical leaders had the right skills and experience to ensure the department was managed effectively.
- However, during the inspection we observed good clinical decision making skills for those patients being managed in the resuscitation area. We noted clinicians used evidence based, nationally aligned clinical protocols for the management of patients who were septic or who had presented with an acute exacerbation of their chronic condition. During the inspection, one senior medic was present in the resuscitation area at all times.
- Although there had been improvements to the number of doctors employed since our last inspection, there remained gaps on the medical staffing rota. This was recognised as being a significant risk for the department and was captured on the departments risk register. Further work was being undertaken to address medical workforce challenges. Consultants were however providing extended levels of cover and were available in the department from 08:00 to 00:00 Monday to Friday. The senior leadership team recognised the need for them to source and recruit a consultant who was a specialist in paediatric emergency medicine due to the numbers of children seen and treated in the department.

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) three 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. National criteria define OPEL three as "Four hour access target significantly compromised; significant numbers of handover delays; patient flow significantly compromised".
- 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.

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 (1 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.

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 that at peak times, they could not accept new patients who arrived by ambulance. 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.
- The hospital had developed a number of simple same day emergency care pathways and services which aimed to avoid admission and speed up treatment. In June 2019, the trust had launched an ambulatory care same day emergency centre. This was led by advanced care practitioners with a consultant. The service aimed to divert from the emergency department up to 25 patients/day with certain day case treatable issues such as deep vein thrombosis, chest pain or cellulitis. At the time of this inspection it was reported the conversion rate through to the same day emergency care service was lower than the trust had aspired for. This was in part due to the fact the service had been relocated on a number of occasions. Staffing challenges had further hampered the effectiveness of the service. Since our last inspection, the service had since been relocated to the emergency department in part to help enhance the visibility of the team.

Inadequate

Urgent and emergency services

Are urgent and emergency services well-led?

Inadequate

Leadership and culture

Operationally, leaders lacked the skills and abilities to run the service. Although they understood and managed 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 on 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. Although we noted some individuals had the ability to lead the service effectively and safely. changes to staffing throughout the shift resulted in people not having the situational awareness to manage the department. 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.' This included a site level vision for Lincoln County Hospital which included a 24/7 emergency department fronted by an Urgent Care Centre with GP streaming, and a 24/7 paediatric emergency department. This strategy was new and the extent to which it had been reflected in divisional planning varied.

For the emergency department at Lincoln, strategic planning to turn the vision into action was fragmented and incomplete. 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 however this investment was being directed towards enhancing emergency care services at Pilgrims Hospital, Boston. There remained no costed strategy at site level which combined quality and safety improvement, workforce planning and training, meeting the RCEM and RCPCH standards, and meeting the needs of children and the full range of patient's individual needs.

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, alack 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. For example, clinical pathways including the standard management of patients who presented with fractured femurs had not been considered or implemented in the department. Challenges in staffing and various departmental moves had meant the same day emergency care model had not delivered the expected results to alleviate pressure on the emergency department.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- 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 on appropriate beds. 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)

This section is primarily information for the provider

Requirement notices

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • 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 on appropriate beds. 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)