United Lincolnshire Hospitals NHS Trust

Pilgrim Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest trusts in the country. The trust serves a population of approximately 700,000 people, situated in the county of Lincolnshire.

We carried out an unannounced focused inspection of the emergency department at Pilgrim Hospital on 25 February 2019. This was to follow up actions the trust had taken following our focussed inspections on 30 November and 18 December 2018.

We did not inspect any other core service or wards at this hospital or any other locations provided by United Lincolnshire Hospitals NHS Trust. During this inspection we inspected using our focussed inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

Pilgrim Hospital, Boston is a large district general hospital located on the outskirts of Boston. At Pilgrim hospital the urgent and emergency services consists of the emergency department (ED), Integrated Assessment Centre (IAC) which included Ambulatory Emergency Care (AEC) and Acute Medical Short Stay Unit (AMSS).

The ED has one triage room, 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 relatives room (which was also used as a mental health assessment room). The department also has one children's cubicle.

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.

Our key findings were as follows:

- The layout of ED was not suitable for the number of admissions the service received. During our inspection we saw significant overcrowding in the department. Throughout our inspection we saw patients being cared for on trolleys in the central area of the department and in the ambulance corridor as there were no free cubicles to use. This had not improved since our last inspection.
- Adults waited on average 81 minutes for treatment. This was against national standards of 60 minutes.
- Whilst the trust had a national early warning scoring system (NEWS) and paediatric early warning scoring system (PEWS) in place, these were not always used as part of the triage process.
- The Royal College of Paediatrics and Child Health (RCPCH) the initialassessment of children should be conducted by an appropriately trainednurse or doctor with paediatric competence. There was not always a paediatric competent nurse performing triage.
- We were not assured children would always be appropriately cared for in the department during 10pm and 10am. We asked the trust to provide us with evidence there was always a registered nurse with the appropriately level of competence to care for children during this time. We found not all shifts were appropriately covered.
- Flow concerns appeared to be 'normalised' and was considered to be a problem for the ED, not the wider trust.
- An ED risk tool gave an "at a glance" look at the number of patients in the department, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. Whilst we saw this updated on a regular basis, we did not see, despite an 'extreme' score, actions taken resulting in an improvement in this position.

Summary of findings

- We saw there were significant issues in relation to patient flow which led to crowding and patients receiving care in corridors. Patients were experiencing unacceptable waits. Whilst staff in the department followed the escalation policy, actions taken by others in line with the policy did not prove effective at restoring flow. The lack of effective actions resulted in handover delays, overcrowding and poor patient experience.

However:

- At the time of this focussed inspection we observed part of one shift. There was good co-ordination between the doctor and nurse in charge.
- Staff at this inspection demonstrated a positive attitude towards their work and were working effectively together.
- Despite the challenges of the department, staff we spoke with were committed to doing the right thing for patients and wanted to deliver safe, effective and compassionate care.
- Since our last inspection the trust had implemented a dedicated frailty team based in the ED, which provided immediate review and care for patients who attended from care homes or where they needed input from older people specialists.
- At this inspection we found improvements in the management of patients who were at risk of deteriorating consciousness levels. We found staff were mostly monitoring these patients effectively. We also found improvements to triage times.
- There had been improvements in the provision of nursing staff for children at this inspection. Between 10am and 10pm there was at least one registered children's nurse present in the department responsible for the care and treatment of children.
- Staff mostly carried out assessments and delivered treatment with privacy, dignity and compassion during all our observations, including during handovers.
- There was a positive regard for patients who were distressed and calling out, we saw nursing and medical staff respond in a timely and appropriate way.
- Patients and relatives, we spoke with were mostly happy with their care and treatment. They said staff were kind and caring and they were doing their best.

Amanda Stanford

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		We carried out an unannounced focused inspection of the emergency department to follow up on actions the trust had told us they had taken following our inspection on 30 November and 18 December 2018 and to see if improvements had been made and sustained. We did not inspect any other core service or wards at this hospital or any other locations provided by United Lincolnshire Hospitals NHS Trust. During this inspection we inspected using our focussed inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

Pilgrim Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

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Background to Pilgrim Hospital

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We previously inspected the emergency department at Pilgrim Hospital using our comprehensive methodology in February 2018. We rated it as inadequate overall. Following our February 2018 inspection Under Section 31 of the Health and Social Care Act 2008, we imposed conditions on the registration of the provider in respect to three regulated activities. We took this urgent action as we believed a person would or may have been exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to the emergency department at Pilgrim Hospital, Boston.

We carried out an unannounced focused inspection of the emergency department at Pilgrim Hospital on 30 November 2018, in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure. There were conditions still in place on the trusts registration in relation to the emergency department at Pilgrim Hospital, Boston. The trust continued to report to us monthly.

On 18 December 2018 we carried out a further unannounced focused inspection of the emergency department at Pilgrim Hospital, this was to follow up actions the trust had taken following our focussed inspection on 30 November 2018.

On 25 February 2019 we carried out a further unannounced focused inspection of the emergency

Detailed findings

department to follow up on actions the trust had told us they had taken following our inspection on 30 November and 18 December 2018 and to see if improvements had been made and sustained.

Our inspection team

The team that inspected the service comprised of Simon Brown, Inspection Manager, Carolyn Jenkinson Head of Hospital Inspection and one other CQC Inspector. A National Professional advisor with expertise in urgent and emergency care supported this inspection.

Facts and data about Pilgrim Hospital

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.

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During the inspection, we inspected the emergency department only. For the purposes of pathway tracking we visited ward 4a (children's ward) to speak with staff only. We spoke in total with 21 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with ambulance crews from the local NHS ambulance trust and some private ambulance service crews who were in the department. We spoke with nine patients. During our inspection, we reviewed 16 sets of patient records and a variety of other information in and around the department.

Urgent and emergency services

Safe	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Summary of findings

- The layout of ED was not suitable for the number of admissions the service received. During our inspection we saw significant overcrowding in the department. Throughout our inspection we saw patients being cared for on trolleys in the central area of the department and in the ambulance corridor as there were no free cubicles to use. This had not improved since our last inspection.
- Adults waited on average 81 minutes for treatment. This was against national standards of 60 minutes.
- Whilst the trust had a national early warning scoring system (NEWS) and paediatric early warning scoring system (PEWS) in place, these were not always used as part of the triage process.
- The Royal College of Paediatrics and Child Health (RCPCH) the initial assessment of children should be conducted by an appropriately trained nurse or doctor with paediatric competence. There was not always a paediatric competent nurse performing triage.
- We were not assured children would always be appropriately cared for in the department during 10pm and 10am. We asked the trust to provide us with evidence there was always a registered nurse with the appropriately level of competence to care for children during this time. We found not all shifts were appropriately covered.
- Flow concerns appeared to be 'normalised' and was considered to be a problem for the ED, not the wider trust.
- An ED risk tool gave an "at a glance" look at the number of patients in the department, time to triage

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and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. Whilst we saw this updated on a regular basis, we did not see, despite an 'extreme' score, actions taken resulting in an improvement in this position.

- We saw there were significant issues in relation to patient flow which led to crowding and patients receiving care in corridors. Patients were experiencing unacceptable waits. Whilst staff in the department followed the escalation policy, actions taken by others in line with the policy did not prove effective at restoring flow. The lack of effective actions resulted in handover delays, overcrowding and poor patient experience.

However:

- At the time of this focussed inspection we observed part of one shift. There was good co-ordination between the doctor and nurse in charge.
- Staff at this inspection demonstrated a positive attitude towards their work and were working effectively together.
- Despite the challenges of the department, staff we spoke with were committed to doing the right thing for patients and wanted to deliver safe, effective and compassionate care.
- Since our last inspection the trust had implemented a dedicated frailty team based in the ED, which provided immediate review and care for patients who attended from care homes or where they needed input from older people specialists.
- At this inspection we found improvements in the management of patients who were at risk of deteriorating consciousness levels. We found staff were mostly monitoring these patients effectively. We also found improvements to triage times.
- There had been improvements in the provision of nursing staff for children at this inspection. Between 10am and 10pm there was at least one registered children's nurse present in the department responsible for the care and treatment of children.
- Staff mostly carried out assessments and delivered treatment with privacy, dignity and compassion during all our observations, including during handovers.
- There was a positive regard for patients who were distressed and calling out, we saw nursing and medical staff respond in a timely and appropriate way.
- Patients and relatives, we spoke with were mostly happy with their care and treatment. They said staff were kind and caring and they were doing their best.

Urgent and emergency services

Are urgent and emergency services safe?

Environment and equipment

- The Emergency Department (ED) had one triage room, 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 relatives room (which was also used as a mental health assessment room).
- The layout of ED was not fit for purpose. During our inspection we saw significant overcrowding in the department. The 'fit to sit' room was overcrowded, patients were sat on chairs and in wheelchairs, receiving intravenous medication. The room posed a risk to the evacuation of patients in the event of a fire or emergency, furthermore there was a risk to health and safety of people using this room as they may trip on drip stands.
- Throughout our inspection we saw patients being cared for on trolleys in the central area of the department and in the ambulance corridor as there were no free cubicles to use. Throughout this inspection the department was overcrowded and we observed, on many occasions, staff struggling to manoeuvre beds and equipment due to the number of trolleys and beds within the department. There was a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell.
- At our previous inspections we observed on many occasions how doctors were unable to sufficiently assess patient's conditions in the department, as there was no space to fully examine them. At this inspection the clean procedures room was used as a room to assess patients whilst cubicles became free. This was an improvement since our last inspection, however did not address the long wait for patients awaiting a medical review.
- We saw resuscitation equipment was safe and ready for use in an emergency. Single-use items were sealed and in date and emergency equipment had been serviced. Records indicated resuscitation equipment had been checked daily or weekly in line with trust policy. This had improved since our last inspection.
- The ED did not accommodate the needs of children, young people and accompanying families in line with the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings. There was no audio and visual separation of the children's waiting area from the adult section, however since our last inspection there had been some improvements to the décor in the children's waiting area.
- The department had a dedicated clinical cubicle / trolley space for children in the major's area and in the resuscitation area. We saw these areas had improved since our last inspection, however the resuscitation area space was restricted as there was lots of equipment in place. Throughout our inspection we saw when children were in the department (numbers permitting) they were treated in the major's cubicle. We did not see adult patients being nursed in the major's cubicle at this inspection. Staff told us children arriving by ambulance would be prioritised for a suitable clinical area. We did not observe any children arriving by ambulance during this inspection therefore we were unable to assess this.

Assessing and responding to risk

- The Royal College of Emergency Medicine (RCEM) 'Initial assessment of emergency department patients' suggests a detailed triage assessment should be made within 15 minutes of the patient's arrival. Following our feedback from previous inspections, the trust had reviewed the staff allocation to triage. They had increased the numbers of triage nurses to two between 10am and 10pm to improve the timeliness of triage. At this inspection we reviewed the ED records for 16 patients (10 adults and six children) who had their triage times recorded. Time from arrival to triage varied between zero and 38 minutes for adults. This was an improvement since our last inspection. The average time adults were waiting to be triaged was 16 minutes. Five out of 10 (50%) adult patients waited over 15 minutes for triage.

Urgent and emergency services

- Children waited on average 10 minutes for triage. Time from arrival to triage varied between zero and 22 minutes. One out of six (16%) children's notes we reviewed waited beyond the recommended 15 minutes.
- The recommended time patients should wait from time of arrival to receiving treatment should be no more than one hour. In December 2018 the median time to treatment was 77 minutes, which was longer then the recommended time and longer than the England average of 60 minutes. The trust median time was generally about 20 minutes longer than the England overall time for all of 2018.
- At this inspection we found the 10 adults we reviewed waited on average 81 minutes to receive treatment, with a range between 50 and 185 minutes. Children waited on average 42 minutes from time of arrival to receiving treatment, with a range between zero and 113 minutes.

- Whilst the trust had a national early warning scoring system (NEWS) and paediatric early warning scoring system (PEWS) in place, these were not always used as part of the triage process. An early warning score is a guide used by healthcare staff to quickly determine the degree of illness of a patient and prompts support from medical staff and/or senior nursing staff when required. We found four out of 10 adult patients notes we reviewed and two out of six children's notes who should have had an early warning score calculated did not have one calculated as part of their initial triage process. We also found this to be the case at our last inspection.
- Once in the main ED, nursing staff used NEWS and PEWS to record routine physiological observations such as blood pressure, temperature, respiratory rate and heart rate. Observations were recorded electronically and included a 'track and trigger' system whereby scores were displayed electronically within the department. At our previous inspections we found staff did not always carry out observations in line with trust protocol and in a timely way. At this inspection we found that this had improved. We saw patient's observations were mostly performed in a timely way. We saw staff escalating patients with increased EWS scores to medical staff. The nurse in charge had oversight of patient's observations if they became overdue and reminded nursing staff to carry these out.
- At our last inspection we found patients who were at risk of deteriorating consciousness levels were not monitored effectively. At this inspection we found this had improved, however, we observed the care of one patient (out of three) with a head injury who despite having neurological observations performed at triage, further neurological observations had not been completed on an ongoing basis in line with trust policy. We alerted the nurse in charge who arranged for these to be carried out. Neurological observations are essential to establish the patient's neurological status and to illustrate any changes.
- We reviewed a patient with a diabetic ketoacidosis (DKA). Diabetic ketoacidosis (DKA) is a serious problem that can occur in people with diabetes if their body starts to run out of insulin. This causes harmful substances called ketones to build up in the body, which can be life-threatening if not spotted and treated quickly. The patient was seen and treated in a timely manner. All the DKA treatment had been commenced in a timely way and there had been sufficient oversight of the patient's care before moving them to a medical ward. Nursing documentation indicated staff had escalated concerns to medical staff in a timely manner and any treatments commenced in timely manner.
- We reviewed the care of three patients who had met the trust criteria for a sepsis screen. We saw sepsis screening had been completed in a timely manner and antibiotics given within an hour in line with best practice. Sepsis is a serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death.

- Staff used a categorisation scale of one to five (one being immediate priority and five least priority) following triage. This should ensure that the sickest patients are seen first. Whilst we saw an improvement in the categorisation at this inspection, we were not assured that all staff understood what this score indicated. Staff told us category one and two patients were to be treated in the resuscitation room, category three in the majors and category four in minors. Priority scores should be based on the patient's clinical condition. We saw a category two patient who had waited two hours and thirty minutes to be moved to the

resuscitation area despite the presenting condition score indicating this on triage. We asked the trust to review this patient care to ensure that no harm had come to the patient as a result.

- The department had three rapid assessment and treatment (RAT) cubicles for the early assessment of 'major's' patients arriving by ambulance. However, we saw the RAT process was ineffective at reducing ambulance handover times. Patients were waiting between 60 and 120 minutes to be clinically assessed by the RAT team.
- At our previous inspection we found there to be a lack of oversight of patients pre- and post-triage in the main waiting room. This had improved during this inspection. Triage nurses kept oversight of the waiting area. We observed care staff performing observations on those patients who had been waiting to be seen by a doctor for significant amounts of time. This ensured any changes to the patient's condition were detected. Reception staff were very complimentary of the additional oversight of the main waiting room.
- At our last inspection we found patients arriving by ambulance and brought into the department were not always clinically assessed appropriately by the Pre-Hospital Practitioner (PHP). The PHP was reliant on observations and assessment from the arriving ambulance crew rather than performing their own. They subsequently recorded this as an assessment time, when in fact there had been no trust clinical assessment of the patient. This posed a risk to patients as the PHP did not have the most up to date information and the patients presenting condition may have worsened. At this inspection we saw the PHP carried out their own assessment in conjunction with the ambulance handover. We also saw appropriate communication between the nurse in charge and the PHP to keep up to date with patient's conditions whilst waiting to be assessed.
- At our last inspection the department had introduced two hourly safety huddles. We saw a safety huddle being performed in the department during our inspection. Staff told us that safety huddles were not performed overnight, but they could request one if the department 'felt out of control' or they had patient safety concerns. Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care.

Nurse Staffing

- The nurse staffing levels and skill mix were sufficient to meet the needs of patients during the period of our inspection; however, we saw and were told there were no plan or actions in place to assess whether nursing staffing levels were sufficient to meet any increasing capacity, demand or patient acuity issues.
- There had been improvements in the provision of nursing staff for children at this inspection. Between 10am and 10pm there was at least one registered children's nurse present in the department responsible for the care and treatment of children. They were clearly identified by a child friendly tabard. The standard operating procedure indicated that there should be a 1:4 nurse to child ratio. Additional support (where staffing levels allowed) was sought from the children's ward.
- For the period during our inspection there were two registered children's nurse present in the department. One had been allocated to triage and one was in the main department.
- We found at this inspection the registered children's nurse had good oversight of children in the department. We observed immediate handover of children post triage to the registered children's nurse. We also saw good links to additional support for the registered children's nurse from the children's ward. A two-hourly call took place between the children's ED nurse and the children's wards nurse in charge. A dedicated phone was in place to support this process, the process was also documented. The children's ward described a positive working relationship with the ED and felt the process worked effectively.
- The Royal College of Paediatrics and Child Health (RCPCH) the initial assessment of children should be conducted by an appropriately trained nurse or doctor with paediatric competence. Nursing and medical staff raised concerns with us that there was not always a paediatric competent nurse performing triage. We asked the trust to provide us with evidence that all shifts were covered by nurses with paediatric

competence. The trust told us in January 2019 there were 6 out of 31 days where there was a nurse in triage that was either Level 4 competent or a Registered Children's Nurse performing triage. They told us however there was always a Registered Children's Nurse or Level 4 competent nurse on duty in the department on these dates. The trust did not provide data for February 2019.

- From 10pm to 10am the trust aimed to ensure an adult nurse with additional paediatric competencies and resuscitation qualification was on duty. They were supported remotely by the children's ward and where staffing allowed a children's nurse from the ward would attend the emergency department. Medical staff on the children's ward further supported nursing and medical staff if this was requested. We asked the trust to provide us with evidence between 10pm and 10am there was always a registered nurse with the appropriately level of competence to care for children during this time. The trust told on four-night shifts in January 2019 there was no nurse with the sufficient competencies or a registered children's nurse in the department. The trust did not provide data for February 2019. We were not assured that children would always be appropriately cared for in the department during this time.

Medical Staffing

- At the time of our inspection there was consultant on the specialist register in the emergency department.
- The staffing levels and skill mix were sufficient to meet the needs of patients during the period of our inspection; however, we saw and were told there were no plan or actions in place to assess whether medical staffing levels were sufficient to meet any increasing capacity, demand or patient acuity issues.
- One doctor in the department had the necessary qualification to care for children and we saw this clearly identified. We saw children were prioritised for review by the doctor allocated to children.

Are urgent and emergency services caring?

Compassionate Care

- Staff mostly carried out assessments and delivered treatment with privacy, dignity and compassion during all our observations, including during handovers.
- There was a positive regard for patients who were distressed and calling out, we saw nursing and medical staff respond in a timely and appropriate way.
- Patients and relatives, we spoke with were mostly happy with their care and treatment. They said staff were kind and caring and they were doing their best.
- At this inspection, as at our last inspections, we found patients cared for in the central area of the main department and on the ambulance corridor. This meant patients privacy and dignity needs were not always respected. We saw many patients being treated in the middle area of the department.
- Ambulance staff transferred patients from the stretcher to trolley in an open area adjacent to an opening door. Ambulance staff told us that they were not meant to do this, however there were no cubicles available to facilitate this.
- We saw patients, whilst cared for by ambulance crews, were left on the back of ambulances for long periods. This was due to lack of capacity in the department. This did not afford patients the dignity they deserved.
- Care rounding documentation was inconsistently completed and it was difficult to establish how long patients waited without any staff checking on them. Our own observations supported that staff checked on patients at regular intervals and provided appropriate levels of support.

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

Access and flow

- At the time of our inspection the hospital was on Operational Pressures Escalation Level (OPEL) 3. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL 1; The local health and social care system

capacity is such that organisations can maintain patient flow and are able to meet anticipated demand within available resources to, OPEL 4; Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care.

- An oFlow concerns appeared to be 'normalised' and was considered to be a problem for the ED, not the wider trust.
- An ED risk tool gave an "at a glance" look at the number of patients in the department, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. Whilst we saw this updated on a regular basis, we did not see despite an 'extreme' score actions taken resulting in an improvement in this position.
- Since our last inspection the trust had implemented a dedicated frailty team based in the ED and provided immediate review and care for patients who attended from care homes or where they needed input from older people specialists. Advanced care practitioners (ACPs) a care home specialist and a consultant with skills to care of the older person provided this service. The aim was to avoid hospital admission or facilitate a timely discharge should they need admission. On average the team were seeing 10-12 patients per day of these half were discharged home. During the period of our inspection we saw six patients seen by the frailty team, of these six, two were prevented hospital admission due to support from this team.
- The frailty team told us the lack of ambulatory care chairs / trolleys prevented them from getting patients out of the department. During this inspection, the ambulatory care area was being used as an inpatient area.
- There was an ineffective system in place for those patients who were clinically stable and referred by a GP. Medical and surgical patients were sent to the ED as there was no space in the hospital to accommodate these patients. This further impacted on the patient wait and the overcrowding in the department. During this inspection we saw four surgical and two medical patients in the department. Due to the lack of clinical assessment in a timely way by medical staff, we saw these patients remained in the department for a significant amount of time and were not sent to a surgical or medical assessment unit within 30 minutes of arrival. This impacted on capacity within the department.
- Medical staff told us there had been improvements in the speciality reviews in the department since our last inspection. They said most specialties were responsive and attended in a timely manner although some were less responsive. During our inspection we saw surgical and medical teams reviewing patients in the department in a timely manner.
- In December 2018 the trust's monthly median total time in A&E for all patients was 210 minutes compared to the England average of 158 minutes. The trust median total time in A&E has been about 50 minutes longer than the England overall since January 2018.
- The proportion of ambulance handovers delayed more than 60 minutes had been worse than England since the beginning of January 2019. From 28 January to 10 February 2019 the trust had 18.1% delayed over 60 minutes compared to England overall which had 2.9%. In January 2019, 83.2% of ambulance journeys had turnaround times over 30 minutes. From 4 February to 17 February 2018 the trust had 20.4% delayed over 60 minutes compared to England overall which had 2.8%.
- Data provided by the local NHS ambulance trust for the week prior to our inspection and up to the day of our inspection (25 February 2019) showed 454 patients attended Pilgrim Hospital by ambulance. Of these 227 (61%) patients waited over 15 minutes to be handed over to the trust, 156 (34%) waited over 20 minutes, 49 patients were waiting between 30 and 59 minutes, 21 patients between 60 and 120 minutes, and three patients waited between two and four hours. The average time to clinical handover was 41 minutes in this time period. During our inspection we observed significant handover delays for patients arriving by ambulance. We saw delays of patients waiting between 15 and 40 minutes to be handed over. We also saw patients waiting on the back of ambulances for between seven and 12 minutes to be brought into the department.

Urgent and emergency services

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From January 2018 to December 2018 the trust failed to meet the standard and performed worse than the England average.
- In Dec 2018, 59.7% of patients spent less than four hours in the Major Type 1 departments at the trust. This was much worse than England's target 95% and worse than the England overall of 79.3%. Data provided by the trust at the time of our inspection indicated in the week prior to our inspection performance was 60.4%.
- Forty percent of patients waited between 4-12 hours from the decision to admit to being admitted. This was similar to England overall but worse than December 2017 which was 31% at the trust.
- Over the 12 months from January 2018 to December 2018, four patients waited more than 12 hours from the decision to admit until being admitted.
- In December 2018 the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was 4.0%, compared to the England average which was 1.8%.

Are urgent and emergency services well-led?

Leadership

- At the time of this focussed inspection we observed part of one shift. There was good co-ordination between the doctor and nurse in charge. The nurse in charge took the main lead in the department. The doctor and nurse in charge communicated on a regular basis. The environment within the ED appeared to be calm and controlled with staff working effectively in their designated zones.
- Since our last inspection the trust had appointed a substantive nursing lead to manage the department. Additional medical support had also been allocated to the department. At the time of our inspection there was no substantive clinical lead for the emergency department at Pilgrim Hospital, however they received one day per week support from the head of service at the other hospital site. The deputy medical director and two external supporting consultants provided additional support throughout the week. Staff told us this led to inconsistency in management. A clinical lead had been appointed as part of the trust divisional restructure and would take up post in April 2019.
- Medical staff told us they did not have regular meetings with key people involved in the improvements of the department and felt that the team on the ground were not always involved in service planning.
- Following our previous inspections, we were told there was executive presence in the department daily to provide support to staff. During our inspection there was no executive presence in the department. Following our inspection, we discussed this with the chief nurse who informed us there had been director presence in the department, however the director had not been aware they were executive for that day.

Culture

- Despite the challenges of the department, staff we spoke with were committed to doing the right thing for patients and wanted to deliver safe, effective and compassionate care.
- Morale in the department was low, this was evident across both nursing and medical staff, however there was an obvious drive from staff to suggest new ways of working to address challenges. Staff told us of some of the improvements since our previous inspection, such as working in different areas and the introduction of the transfer team.
- Staff at this inspection demonstrated a positive attitude towards their work and were working effectively together.
- Medical staff told us of inconsistencies in leadership and how various people would come in and out of the department to provider support, however this was not consistent. Staff told us this left them feeling frustrated.
- Locum medical staff told us there was a lack of access to teaching and training within the department, however said they received a good level of supervision.

Urgent and emergency services

Managing risks, issues and performance

- We saw there were significant issues in relation to patient flow which led to crowding and patients receiving care in corridors. Patients were experiencing unacceptable waits.Whilst staff in the department followed the escalation policy, actions taken by others in line with the policy did not prove effective at restoring flow. The lack of effective actions resulted in handover delays, overcrowding and poor patient experience.
- At this inspection, the shift management of risks, issues and performance in the Emergency Department (ED) appeared effective. At our last inspection, we had to escalate many immediate patient safety concerns to medical and nursing staff to keep patients protected from avoidable harm, this was not the case at this inspection and the nursing and medical teams had sufficient oversight of the patients in the department at the time of our inspection.
- Two hourly huddles took place in the department as further measure to identify and address new or emerging risks. We saw a “message of the day” board use to cascade key patient safety messages for that day.

Outstanding practice and areas for improvement

Areas for improvement

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

- The trust must should ensure the emergency department risk assessment tool is updated appropriately and in a timely manner and that actions are taken based on the score.
- The trust must ensure triage is only undertaken by a registered healthcare professionals that are experienced in emergency/urgent care and have received specific triage training this includes additional competencies for those caring for children in line with The Royal College of Paediatrics and Child Health (RCPCH) .
- The trust must ensure an effective process is operating to ensure there is a senior doctor assessment, rapid assessment and treatment or early senior assessment process in place for patients brought in by ambulances, and those who are waiting in the corridors and in the ambulances.
- The trust must ensure that there are sufficient numbers of suitably qualified staff competent to care for children (above and beyond paediatric resuscitation training) on duty in the emergency department at all times.
- The trust must ensure the environment in the emergency department accommodates the needs of children, young people and accompanying families in line with the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (2012).
- The trust must ensure the environment in the emergency department is fit for purpose and that actions are taken to address the risk to patients due to overcrowding.
- The trust must ensure the level of risk in the emergency department is identified, recorded and managed appropriately.
- The trust must ensure there is an effective system in place for those patients who were clinically stable and referred by a GP to be fast tracked through the emergency department.
- The trust must ensure a full capacity protocol is in place and that this operates effectively to restore flow in the ED.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance