Shrewsbury and Telford NHS Trust

The Princess Royal Hospital

Quality Report

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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

This was a focused inspection to review concerns relating to the emergency department. It took place between 1pm and 9pm on Monday 15 April 2019.

We did not inspect the whole core service therefore there are no ratings associated with this inspection. We also inspected the Royal Shrewsbury Hospital as part of this inspection. Due to the nature of services and same leadership team, there are similarities across both location reports.

Our key findings were:

- Provision for mental health patients was not consistent with national best practice standards. The environment in which patients presenting with mental health conditions had not been risk assessed, despite this being noted as an area for improvement following our previous inspection. The environment continued to present risks including ligature points.
- The initial management of patients who self-presented was poor. Health professionals deviated from the trusts standard operating procedure for the streaming of patients. This meant patients experienced significant delays in having a full clinical assessment which should have occurred in a timely way as defined by national standards.
- The management of children was poor. There was no clearly defined escalation or prioritisation protocol. Increased demand for services meant children were leaving the department without being seen and without having received appropriate clinical assessments.
- The department implemented patient safety initiatives including early warning systems and patient safety checklists however staff did not consistently use these.
- There were occasions when the privacy and dignity of patients was not always promoted or protected.
- Compliance against constitutional standards remained challenging. Local escalation protocols failed to deliver the necessary action to decompress the emergency department.
- There remained a focus on delivering performance and avoiding twelve-hour breaches as compared to providing holistic care to patients; this was compounded by continued challenges around bed capacity and the estate.
- Whilst clinical governance processes existed, the information used to provide assurance was not sufficiently robust.
- Morale remained low although it was reported to be improving.

As a result of this inspection, we opted to utilise our enforcement powers and imposed urgent conditions of the Provider's registration. Namely,

1. The registered provider must ensure that within three days of this notice, it reviews and implements an effective system with the aim of ensuring that all children who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines.
2. The registered provider must ensure that the staff required to implement the system as set out in the previous condition are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately.
3. The registered provider must ensure that the system makes provision for effective monitoring of the patient's pathway through the department from arrival.
4. The registered provider must provide the Commission with a report setting out the steps it has taken to implement the system as required in conditions two to three, within five days.
5. The registered provider must ensure there is a system in place which ensures that all children who leave the emergency department without being seen are followed up in a timely way by a competent healthcare professional.
6. From 26 April 2019 and on the Friday of each week thereafter, the registered provider shall report to the Care Quality Commission describing the system in place for effective management of children through the emergency care pathway. The report must also include the following:

Summary of findings

a. The actions taken to ensure that the system is implemented and is effective.

b. Action taken to ensure the system is being audited monitored and continues to be followed.

c. The report should include results of any monitoring data and audits undertaken that provide assurance that a process is in place for the management of children requiring emergency care and treatment.

d. The report should include redacted information of all children who left the department without being seen; details of any follow-up and details of any harm arising through the result of the child leaving the department without being seen.

1. The registered provider must ensure that within three days of this notice, it implements an effective system with the aim of ensuring that all adults who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines.
2. The registered provider must ensure that the systems in place across the department can account for patient acuity and the location of patients at all times.

The trust must also ensure

They operate an effective clinical governance process which is supported by reliable and tested information and datasets.

Ensure staff receive feedback on incidents and outcomes from morbidity and mortality reviews.

Ensure staff comply with local hand hygiene and infection control protocols.

Professor Edward Baker
Chief Inspector of Hospitals

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 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. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused 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. We did not inspect the whole core service therefore there are no ratings associated with this inspection. We found that: • Provision for mental health patients was not consistent with national best practice standards. The environment in which patients presenting with mental health conditions had not been risk assessed, despite this being noted as an area for improvement following our previous inspection. The environment continued to present risks including ligature points. • The initial management of patients who self-presented was poor. Health professionals deviated from the trusts standard operating procedure for the streaming of patients. This meant patients experienced significant delays in having a full clinical assessment which should have occurred in a timely way as defined by national standards. • The management of children was poor. There was no clearly defined escalation or prioritisation protocol. Increased demand for services meant children were leaving the department without being seen and without having received appropriate clinical assessments. • The department implemented patient safety initiatives including early warning systems and patient safety checklists however staff did not consistently use these. • There were occasions when the privacy and dignity of patients was not always promoted or protected.

Summary of findings

- Compliance against constitutional standards remained a challenging. Local escalation protocols failed to deliver the necessary action to decompress the emergency department.
- There remained a focus on delivering performance and avoiding twelve-hour breaches as compared to providing holistic care to patients; this was compounded by continued challenges around bed capacity and the estate.
- Whilst clinical governance processes existed, the information used to provide assurance was not sufficiently robust.
- Morale remained low although it was reported to be improving.

The Princess Royal Hospital

Detailed findings

Services we looked at
Urgent and emergency services;

Detailed findings

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Background to The Princess Royal Hospital

We carried out an unannounced focused inspection of the emergency department at The Princess Royal Hospital on 15 April 2019, 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.

We did not inspect any other core service or wards at this hospital, however we did visit the admissions areas to discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

We previously inspected the emergency department at The Princess Royal Hospital in August 2018. We rated it as inadequate overall and opted to use our urgent enforcement powers to ensure prompt action was taken to address concerns identified during the inspection.

Following this most recent inspection, we again took urgent action to ensure the provider took swift action to address system failings in relation to the triaging and continued clinical assessment of all patients who presented to the emergency department.

Our inspection team

The team that inspected the service comprised of Zoe Robinson, Inspection Manager, one other CQC inspector, a national professional advisor with expertise in urgent and emergency care and an emergency department matron specialist advisor. The inspection was overseen by Victoria Watkins, Head of Hospital Inspection.

Urgent and emergency services

Safe	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The Emergency Department (ED) at The Princess Royal Hospital provides services 24-hours per day, seven days per week service.

The Princess Royal Hospital ED provides care and initial treatment to patients presenting with injuries or illness in the event of an accident or emergency. The Princess Royal Hospital had a major's unit as well as a minor injuries unit and a clinical decision unit. The department was also supported by a recently commissioned urgent care centre.

Both sites across the trust have acute medical units where patients are initially admitted from either the emergency department or through GP referral (referral via the care co-ordination centre). Patients with conditions that can be diagnosed/treated without the need for admission may be seen and treated in the ambulatory emergency centre (AEC) which was led by general practitioners and advanced nurse practitioners.

The internal layout of the ED comprised of a main waiting area. Within this area there were two hatches; one where patients could book in and one to see a streaming nurse who subsequently decided the most appropriate care pathway for the patient (minors, majors or urgent care). A triage room led off the main waiting room. Within the treatment areas were four 'minors' cubicles (for patients with minor injuries and illness), eight 'majors' cubicles (for patients with major illness or injury) and a paediatric treatment room. In addition, there were two 'pit stop' cubicles where rapid assessments took place following triage, and two areas for 'fit to sit' patients. One of these cubicles had chairs where patients who were well enough could sit and await further assessment. The other 'fit to sit' cubicle had a bed where patients could be examined individually if necessary.

The resuscitation area comprised a large room with four open bays; one of which was designated for paediatric patients. A Clinical Decisions Unit (CDU) had recently been opened (June 2018) which had two fully equipped bedded cubicles; and two cubicles for seated patients. This area was closed on the day of the inspection due to staff shortages.

Between August 2017 and July 2018; The Princess Royal Hospital had a total of 66,838 attendance at Accident and Emergency. This was broken down further to 60,308 attendances at ED and 6,530 at the Urgent Care Centre (UCC).

Between August 2017 and July 2019; 16,164 children (under 18 years) attended the accident and emergency services at The Princess Royal Hospital. This was broken down further to 1,912 attended the UCC, and 14,252 attended ED.

During the inspection we spoke with 16 staff members which included doctors, nurses, healthcare assistants (HCAs), housekeeping staff and members of the trust executive team. We looked at 32 sets of patient records. We spoke with nine patients about their care; and spoke with 12 relatives/ carers who accompanied patients who attended during our inspection.

Urgent and emergency services

Summary of findings

We did not inspect the whole core service therefore there are no ratings associated with this inspection. We found that:

- Provision for mental health patients was not consistent with national best practice standards. The environment in which patients presenting with mental health conditions had not been risk assessed, despite this being noted as an area for improvement following our previous inspection. The environment continued to present risks including ligature points.
- The initial management of patients who self-presented was poor. Health professionals deviated from the trusts standard operating procedure for the streaming of patients. This meant patients experienced significant delays in having a full clinical assessment which should have occurred in a timely way as defined by national standards.
- The management of children was poor. There was no clearly defined escalation or prioritisation protocol. Increased demand for services meant children were leaving the department without being seen and without having received appropriate clinical assessments.
- The department implemented patient safety initiatives including early warning systems and patient safety checklists however staff did not consistently use these.
- There were occasions when the privacy and dignity of patients was not always promoted or protected.
- Compliance against constitutional standards remained a challenging. Local escalation protocols failed to deliver the necessary action to decompress the emergency department.
- There remained a focus on delivering performance and avoiding twelve-hour breaches as compared to providing holistic care to patients; this was compounded by continued challenges around bed capacity and the estate.
- Whilst clinical governance processes existed, the information used to provide assurance was not sufficiently robust.
- Morale remained low although it was reported to be improving.

Are urgent and emergency services safe?

As this was a focused inspection, we have not inspected the whole of this key question therefore there is no rating. We found that:

- Whilst there had been some improvements to the environment, there remained shortfalls in the suitability of the clinical environment for the management of high risk patients.
- The initial assessment and streaming processes for patients who self-presented to the department were not fit for purpose.
- The arrangements relating to the management of children who presented to the department was not aligned to national standards. There were no escalation or prioritisation protocols in place for when the department was in a status of surge.
- Challenges remained in relation to the employment and deployment of appropriately qualified and competent staff.
- There remained inconsistencies in the use of early warning scoring systems.

Environment and equipment

- We previously reported concerns regarding the general environment and storage or equipment in the emergency department. In part, this was due to the building work of a new urgent care unit which meant some areas of the existing emergency department had been decanted, resulting in equipment being stored in inappropriate places such as unlocked cabinets in corridors. Further, temporary access arrangements placed patients and visitors at risk of harm because of the proximity of reversing vehicles and poor access for patients with disabilities or reduced mobility. We also raised concerns over the suitability of the environment regarding the management of patients who presented as high risk of self-harm or those with suicidal tendencies. This was because there was no appropriate safe area for such patients to be managed whilst their care needs were assessed and more appropriate clinical settings were organised. We followed up on these areas as part of this most recent inspection to determine whether improvements had been made.
- At this recent inspection, the building work had been concluded, with the urgent care unit observed to be in

operation. In the main, equipment was stored appropriately with consumable equipment stored in locked rooms. We did note a range of substances hazardous to health including actichlor and formalin stored in an unlocked cabinet in an unlocked seminar room which was easily accessible from the main corridor of the emergency department. Access was appropriate for those with reduced mobility. However, the provision for those patients with mental health needs, and especially those who presented with suicidal tendencies remained poorly mitigated against. The senior leadership team reported that environmental risk assessments were scheduled to be carried out over the three-day period of 15-17 March 2019, in preparation for a planned visit from Mental Health Act reviewers the following week. This was despite CQC raising concerns over the suitability of the environment and a lack of risk assessment following our previous inspection in August 2018. Staff directed the inspection team to a small interview room which they reported was the preferred area for seeing and treating high risk mental health patients. The room remained non-compliant with national best practice standards. Ligature points remained present with little in the way of mitigation. Light weight, unsecured chairs were located across the room. These presented as a risk to patients, staff and visitors in that they were sufficiently light-weight to be picked up and thrown. The room had only one point of access and exit, and it was possible for the door to be blocked from the inside, resulting in staff experiencing delays in a clinical emergency should the patient decide to barricade the door. Senior clinical staff acknowledged the environment was not suitable and that they mitigated against the risk by ensuring high risk patients were nursed on a one-to-one basis. However, some staff reported staffing challenges meant this was not always possible. Further, the environment was not sufficiently safe to ensure that during times of extreme agitation or distress, staff and visitors had alternative exit routes from the designated room.

- The congested nature of the department meant patients could not always be nursed on hospital beds whilst they remained in the emergency department once a decision to admit had been made. Some staff reported a lack of physical beds often meant patients experienced long periods of time on a trolley. We observed this during the inspection when we noted one elderly patient having remained on a trolley for a period of approximately ten hours, therefore increasing the patients risk of skin damage through poor pressure relieving practices. Although the patient had an emergency department safety checklist filed in their notes, there was no reference to the patient having been supported to be repositioned to reduce the risk of pressure damage from occurring.
- We spoke with three patients who were being nursed on the corridor. Two patients had relatives present with them who could seek help from staff should the need arise. However, one patient reported the sense of being distressed and isolated because they had no means of calling for a nurse or other health professional due to a lack of call bell being presented. We observed multiple occasions, especially during peak activity when the nurse allocated to the corridor was not present, nor had direct line of sight of all patients. The lack of a call bell or other method or seeking help in an emergency presented a risk to those patients being cared for along the main corridor. We noted patients in cubicles had access to call bells so they could raise the alarm or could seek help with relative ease.
- Staff had access to a sepsis trolley which was in the major's department. The trolley contained step by step guidance and all the items required to deal with a suspected sepsis patient quickly, for example, medicines and fluids. A junior doctor was identified each day to carry a dedicated sepsis bleep and this was observed during the inspection. This doctor was responsible for responding to any patient who was identified as being potentially septic, in order that timely treatment could be commenced.

Assessing and responding to patient risk

Risks to patients were not always assessed and their safety was not consistently monitored and managed so they were supported to stay safe.

- The management of patients who self-presented to the emergency department posed a risk to the safety of patients. The process by which staff assessed and recognised the acutely unwell or deteriorating patient was poorly thought through and poorly executed. Patients who self-presented were initially signposted to book in with a non-clinical receptionist who took demographic details and recorded the presented

complaint. Patients were then asked to wait in the waiting room until they were called by a streaming nurse who was located at a second window in the main waiting room. The streaming nurse was sat behind a glass screen and we noted on multiple occasions when patient names were called but due to the size of the waiting room, the busy nature or the area and the poorly located streaming bay, patients did not always hear their names being called. On one occasion, we were present when a patient spoke with a receptionist as they had been in the department for three hours and had not been seen by any health professional. The patient had been discharged from the system as having left the department without being seen; the patient had in fact been in the department but had not heard their name being called by the streaming nurse.

- We observed the streaming process and noted that not all patients were called to be assessed by the streaming nurse. We discussed this with a senior member of the nursing team who reported their expectation was that all patients who self-presented were reviewed and streamed, with no exceptions. The streaming nurse reported they used their professional judgement when determining whether a patient needed to be seen by them, or whether the streaming nurse could automatically allocate the patient to the most appropriate clinical streaming pathway, be it minors, majors or the urgent care centre. The streaming nurse gave examples of cases which would not be called for assessment including those who presented with genital complaints or bleeding from the bowel. The nurse reported this was due to the lack of privacy and sensitive nature of presenting complaints, and therefore opted to stream patients without physically speaking with the patient. We also observed the wife of an elderly patient who presented with shortness of breath, checked her husband in with the clerical team on her husband's behalf who was observed seated in the waiting room. When called to see the streaming nurse, the wife of the patient attended the streaming window without her husband; the patient was streamed to triage without any visual assessment of the patient. Therefore, there was no formalised assessment of the patient to determine their severity of respiratory distress. The patient was then noted to experience a delay in triage due to increased activity of the department.
- We observed delays of up to one hour and ten minutes from booking in with the reception staff to being called for streaming; this included a patient who presented with stroke like symptoms. Once streamed by the streaming nurse, patients identified as entering the major's pathway were then allocated to the triage nurse to determine the clinical priority of the patient. Delays of up to one hour for triage following streaming were noted. This included one patient who presented with stroke like symptoms and another patient who presented with chest pain. Whilst both patients were seen by the streaming nurse, there was no ability for the streaming nurse to undertake physical observations of patients and therefore the clinical status of the patient could not be fully assessed; this was reported to be the role of the triage nurse. Nursing staff reported they would fast-track any patient who looked extremely unwell, otherwise, all other patients were required to wait to be seen by the triage nurse before physical observations were undertaken.
- Streaming and triage nursing staff reported patients were expected to self-manage and escalate any changes to their condition as compared to there being any formalised clinical oversight of the waiting room; this was consistent with the views of consultants also. This meant there was some risk patients could deteriorate in the department without any health professional intervention unless the patient or others recognised the patient as deteriorating.
- During this inspection, we were informed that between 13 and 14 April 2019, 11 children attended the emergency department and subsequently left without being seen due to long waits in the emergency pathway. We reviewed the case notes for each of the 11 children. Of those reviewed, only one patient had had any form of initial triage recorded despite children presenting with possible signs of sepsis including but not limited to a high temperature or rash. We noted that one child presented with a possible foreign body in their throat; whilst the case was considered by the streaming nurse, there had been no formalised triage of the child and no observations recorded. Three children aged one year or under presented with a history of fever. A review of case notes confirmed no triage or observations had been completed for those children who subsequently left the department without being seen.
- A young female presented at the early stages of pregnancy with a two-day history of lower abdominal pain. Whilst an initial set of observations were recorded and an early warning score of 0 logged on the patients

record, the individual left the department without being seen. There was no consideration that this individual may have been experiencing an ectopic pregnancy which could have resulted in significant harm or death if left untreated.

- The trust was not reporting nationally the time it took for them to undertake an initial clinical assessment for patients arriving by ambulance. National standards state that all such patients should undergo a formal clinical assessment within fifteen minutes of arrival. We spoke with the senior leadership team who could not inform us why the reporting was not occurring nationally. However, we observed during the inspection that patients arriving by ambulance were directed to the pit-stop area during which clinical assessments were undertaken; in most of cases, such assessments took place within fifteen minutes, with ambulance crews reporting minimal delays.
- From 18 February to 3 March 2019 4.85% of patients arriving by ambulance had handovers delayed more than 60 minutes. This was similar to the England performance(Source: NHS England - Winter Daily SitRep).
- NHS England 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 once in the 12-month period from February 2018 to January 2019. From February 2018 to January 2019 the median time was generally longer than 90 minutes. In January 2019 the median time to treatment was 88 minutes compared to the England average of 63 minutes (Source: NHS Digital - A&E quality indicators).

- Staff used an early warning scoring system to help them to recognise the deteriorating patient. However, we noted the use of the scoring system to be inconsistent with examples whereby staff did not routinely follow trust protocols. For example, where patients scored a three on the early warning system, there was a requirement for staff to undertake further observations at intervals of one hour. During the inspection we reviewed 32 sets of notes. In three sets of notes, patients experienced delays of up to two hours and thirty minutes between observations. This meant patients were at risk of deteriorating without appropriate clinical oversight. Further, where patients had received an initial clinical assessment, patients then experienced delays in having further clinical reviews and interventions. For example, in one case, a patient presented with exacerbation of asthma. The ambulance crew reported the patient was “Tripoding” (this is a natural position adopted by patients experiencing respiratory distress and is common in those with acute exacerbation of asthma) and the patient was unable to complete sentences. No formalised respiratory asthma pathway was used. Although observations were completed at 06:00 and 08:00, and the patient scoring three on the early warning system, the patient was not seen by a doctor for a period of almost two hours at which point clinical treatment was commenced. The initial management and treatment of the patient deviated from national standards as set out by the Royal College of Emergency Medicine in regard to the management of moderate and acute asthma.
- Whilst staff utilised a sepsis screening tool for most patients who presented to the department, the assessment and management of sepsis was not always holistic, nor was it robust. Further, where nursing staff utilised early warning systems for the management and recognition of the deteriorating patient, other health professionals, including doctors, did not always apply trust protocols in terms of responding within defined timeframes. For example, an elderly patient presented with a shortness of breath and confusion. A sepsis screen was completed approximately twenty minutes after the patient arrived. The patient had a recorded early warning score of eight (this suggested the patient was acutely unwell and possibly in a state of pre-arrest). The patient was reviewed by a doctor one hour after the sepsis screen was completed. The patient continued to deteriorate despite having had an initial clinical review and referral to the medical speciality, two hours and thirty minutes after arrival. Nursing staff escalated the worsening condition of the patient to medical staff as the patients work of breathing was such the patient was becoming cyanotic. Medical notes suggest the medical registrar was not available to review the patient and the emergency department speciality registrar was reported to have refused to review the patient, despite the notes of the patient being placed in the departments red escalation folder. This folder had been introduced following previous serious incidents in which patients had not been reviewed by medical staff in a timely way or had not been escalated by nursing staff at the point a patient’s condition had deteriorated. The nurse caring

for the patient subsequently escalated the patient to the nurse in charge, with medical notes recording the patient as being reviewed one hour after the initial escalation. There was evidence of inconsistent application of the early warning escalation system. We also noted that despite the patient having a warning score of 10 at 07:10, further observations were not recorded until 09:50.

- Departmental leads could not provide appropriate evidence to demonstrate that those nurses providing care to children had completed any recognised formal competency training as defined by national standards. We had previously raised this with the trust who had since reported that all band six nurses working in the department had completed European paediatric life support training (EPLS). The scope of this training however did not extend to the holistic assessment of children, including the psycho-social needs of children and the family. During our inspection, nurses allocated to care for children had not completed EPLS training and were reported to be band five nurses. Therefore, the mitigations provided by the trust were currently not sufficient to demonstrate services provided to children were sufficiently safe.

Nurse staffing

- At our previous inspections, we had reported consistent challenges regarding the employment retention and deployment of nursing staff across the emergency department. At this inspection, an interim lead nurse had been appointed to provide nursing leadership and to undertake an assessment of the emergency care pathway. The lead nurse had undertaken a staffing review of the nursing establishment at both The Princess Royal Hospital and Royal Shrewsbury Hospital emergency departments. It was noted there had been a significant and sustained shortfall in the nursing establishment. A revised nursing establishment assessment had been undertaken and approval had been provided by the trust board for the lead nurse to undertake an extensive recruitment campaign. The review, which considered best practice guidance from the emergency care intensive support team (ECIST), had been benchmarked against similar sized emergency departments to ensure the proposed new establishment was like that of other departments treating similar numbers of patients. There was recognition amongst the local leadership team that nursing recruitment would be an on-going challenge, and would likely not be resolved for a period of at least three years, due to the significant historical shortfalls. Prior to the workforce review, there were 8.4wte nurses. Post review, this had increased to 55 whole time equivalent nurses who were to be recruited to support both emergency departments. An additional 11.2 wte band 7 senior nurse posts had been created and were to be introduced over a three year period. At the time of the inspection, 3.8wte band 7 nurses were in post with the trust reporting this had increased to 4.8 wte shortly prior to the publication of this report.
- Departmental leaders reported continued challenges in ensuring the nursing rota was sufficiently supported by competent staff. Senior leaders raised concerns over the competence of some existing band six nurses, with a lack of experience and knowledge being reported as the main areas of concern. Development and competency frameworks were being developed to help support individuals new to the role of the band six emergency department nurse.
- During the inspection, the clinical decision unit had been closed due to a shortfall in the number of nurses available. This was due to three nurses reporting sick at short notice, resulting in a decision being made to close the clinical decision unit in order nursing staff could be deployed to the areas of greatest risk. We noted during the inspection staff from other clinical areas including intensive care, being deployed to support the emergency department. Whilst these individuals worked substantively for the trust, they were unfamiliar with the department and were not competent in the delivery of emergency nursing care and so were deployed to areas including the main corridoras compared to providing immediate emergency care to newly arriving patients.. Senior leaders reported a continued reliance on temporary nursing staff to support the department. Where possible, known agency staff were block booked to cover vacant shifts; this allowed those individuals to become familiar with the team and the working practices of the department. Staffing was reviewed throughout the day to ensure the department aimed to have the right number of staff deployed across all relevant areas.
- We had previously raised concerns over the lack of planning regarding nurse staffing for the emergency department. For example, it had been standard practice for nursing staff to not be routinely assigned to the

underutilised resuscitation area, with an expectation nursing staff from majors would attend if required. At this inspection, there was greater emphasis on ensuring there were sufficient nurses to support each of the clinical areas. However, we noted the resuscitation room continued to remain underutilised. Staff reported this was due to the location of the resuscitation room which was some way from the main emergency department. A nurse however was assigned to staff the resuscitation room but was noted to support the major's department due to a lack of activity in their designated clinical area.

- Despite The Princess Royal Hospital being the regional designated children's hospital, there was not sufficient registered sick children's nurse to cover every shift. At the time of the inspection, the trust had three children's nurses employed to support both the emergency departments. We had previously raised this as an area of concern. Despite CQC raising these concerns, the trust had continued to fail to ensure that those nursing staff designated to care for children, were sufficiently competent. Junior nursing staff reported they had attended annual paediatric update sessions however they had not completed any formalised competency based training.

Medical staffing

There were not always enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.

- We had previously reported the department had experienced significant challenges in the recruitment and retention of doctors across all grades. At our previous inspection, the trust reported having had only three substantive consultants to support the delivery of both the emergency departments operated by the trust. At this inspection, progress had been made in the recruitment and retention of consultants, with the trust now reporting seven consultants as being in post with agreed funding in place for an additional five whole time equivalent consultants.
- The trust could provide consultant presence in the emergency department seven days a week. However, the department could not consistently provide 16 hours of cover each day. The clinical lead aimed to ensure a consultant was present from 8am to 10pm Monday to Friday and from 8am to 4pm at weekends. A review of the staffing rota for the week of 15 April 2019 showed variability in the level of consultant presence. However, the department recognised peak periods and so ensured a consultant was present in the department until midnight on Mondays. Consultant presence was organised until 10pm on Tuesday; 8pm on Wednesday; 9pm on Thursday and 8pm on Friday.
- Arrangements were in place for ensuring a consultant was on-call to solely cover The Princess Royal Hospital emergency department out of hours; this was an improvement when compared to our previous inspection when the on-call consultant was expected to cover both emergency departments.
- Senior clinical staff reported continued challenges with ensuring sufficient numbers of middle grade doctors were available to cover shifts. Approximately 60% of clinical shifts were staffed by locum staff, with substantive staff reporting variability in the quality and competence of individuals. The department reported 11.5 whole time equivalent middle grade doctors, of which only two were at specialist trainee grade four or above.
- Although the department saw over 16,000 children a year there was no designated paediatric emergency medicine consultant, as recommended by the Royal College of Emergency Medicine and Royal College of Paediatrics and Child Health. This was recognised as an area for improvement by the clinical lead of the emergency department who reported generic adverts for the remaining substantive consultant posts also included the need for a PEM consultant to help support and guide the paediatric service.
- Junior doctors spoke positively about working in the emergency department. They told us the consultants were supportive and always accessible. Opportunities were present for training and education however junior doctors reported limited feedback on incidents, serious incidents and from morbidity and mortality reviews.

Are urgent and emergency services caring?

Compassionate care

- We had previously reported that patients spoke positively about the way they were treated by nursing staff and health professionals in general when accessing

care in the emergency department. During this inspection we observed staff speaking to patients with compassion and respect. The streaming nurse raised concerns over the lack of privacy to enable her to undertake thorough assessments of patients in the main waiting room. We raised similar concerns at our previous inspection when we found that overnight, ambulatory patients were being triaged in the main waiting room, thus compromising their privacy.

- Due to the congestion within the department, there were occasions when patients were being nursed in corridors. In most cases, patients were covered with blankets and their personal needs were reported to be met. However, we noted on one occasion when a member of nursing staff had provided two male patients with urine bottles with an expectation the patients urinated whilst laying on trolleys in the main corridor. The inspection team interjected and requested the nurse found a more appropriate setting which would ensure the privacy and dignity of both patients; this could have included transferring the patients to a vacant cubicle in the closed clinical decision unit. We raised our concerns over this lack of foresight to the nurse in charge of the department.

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

As this was a focused inspection, we have not inspected the whole of this key question therefore there is no rating. We found that:

- Patients could not always access the service when they needed it in a timely way. This meant that patients experienced unacceptable waits to be admitted into the department, receive treatment and be discharged. Waiting times and arrangements to admit, treat and discharge patients were not in line with good practice.

Access and flow

Patients could not always access the service when they needed it in a timely way. This meant that patients experienced unacceptable waits to be admitted into the department, receive treatment and be discharged. Waiting times and arrangements to admit, treat and discharge patients were not in line with good practice.

- At our previous inspection, we had reported the trust was engaged in a public consultation to seek the views of local people regarding changing the level of provision of emergency care services across Shropshire, Telford and Wrekin and Mid Wales. At that time, consideration was given to reducing the operating hours of the emergency department at The Princess Royal Hospital. At this inspection, no formal decision had been made, however the trust recognised the need for emergency services to be available across both the acute locations of Shrewsbury and Telford NHS Trust.
- At the time of our inspection the hospital was operating at a heightened state of escalation. Local leaders were not familiar with the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). 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.
- During this inspection the department was under immense operational pressure. Increased attendances from both ambulance conveyances and self-presenting patients was reported to be placing the department and wider hospital under pressure. Flow through the emergency pathway was stagnated, with six patients reported to have experienced delays of more than 12 hours from the time a decision to admit was made to those patients leaving the department; these six cases were reported to have been logged as single serious incident.
- The emergency department was congested with patients experiencing delays in all aspects of their care from initial assessment thorough to review by speciality doctors. The stroke pathway was placed under exceptional pressure with eight possible stroke cases noted to be in the department at one moment in time

during the inspection. Whilst an experienced stroke nurse was assessing patients, the workload meant patients experienced delays in their assessments and on-going care planning; we noted little support from medical colleagues to support the stroke nurse during the period of increased activity. There was little engagement of speciality doctors, including acute medics to reduce the residual risk associated with the congested emergency department. The chief operating officer facilitated a capacity and demand situational report call across both acute sites at 4pm on the day of the inspection. The call was used to assess the status of the emergency pathway; to consider staffing challenges and to consider actions for those patients nearing their twelve-hour breach time. However, the meeting delivered very few actions; was orientated towards performance as compared to safety and quality; and ultimately, offered little in the way of effective management or resolution to the demands experienced by the emergency department.

- The hospital had been slow to introduce effective measures to help reduce occupancy and length of stay in the emergency department. There had been significant focus placed on addressing the four-hour performance target within the minor's pathway. However, a lack of effective or robust frailty pathway for example, meant those patients who required extended lengths of time in the emergency department, but who could ultimately be discharged home or to other places of safety had received little focus. Referral patterns to the ambulatory care pathway was reported to be limited, especially considering the fact the ambulatory unit was hosting inpatients at the time of the inspection, in line with the trusts escalation and bed management protocol; this reduced the capacity of ambulatory medics to undertake increased activity to help decongest the emergency pathway. The clinical decision unit had been closed based on a lack of nursing staff to support the unit. This resulted in additional patients being held in the emergency department pending test results, or increased levels of treatment for patients who would ultimately be discharged within a short period of time. The number of patients referred to the clinical decision unit was reported to be low, raising doubts over the effectiveness of the clinical decision unit. We observed multiple patients in the emergency department who were awaiting test results or who required slightly extended levels of care who could have been effectively managed in the clinical decision unit if sufficient staff had been available to support the unit.
- Staff reported multiple patients presenting to the emergency department having been referred to medical or surgical specialities. Commonly referred to as "GP expected" patients, staff reported significant delays with medical speciality doctors attending the emergency department to review these patients; subsequently adding to the congestion of the department. At approximately 5pm on the day of the inspection, we noted the waiting room was full, with standing room capacity only for newly presenting patients.
- From February 2018 to January 2019 the total time (median) in A&E was consistently longer but within statistically similar levels to England. In January 2019 the trust's monthly median total time in A&E for all patients was 179 minutes compared to the England average of 164 minutes. (Source: NHS Digital - A&E quality indicators).
- In January 2019, 61.3% of patients spent less than four hours in the trust's major A&E departments. This was worse than the national performance (76.1%) and much worse than the standard (95%). (Source: NHS England - A&E SitReps
- In January 2019 55% of patients waited between four and 12 hours from the decision to admit until being admitted. (Source: NHS England - A&E SitReps)
- Over the 12 months from March 2018 to February 2019, 64 patients waited more than 12 hours from the decision to admit until being admitted. This was much worse than expected. Forty-five of these patients were in January and February 2019. (Source: NHS England - A&E Waiting times)

Are urgent and emergency services well-led?

Leadership

- The service was managed by an interim lead nurse who had been seconded from their substantive role, in part because of their operational and nursing experience of managing emergency departments. The lead nurse was supported by a clinical lead who was a substantive emergency care consultant. To complete the leadership

team, a care group manager was in post whose remit was focussed around operational performance. There was a generally good understanding amongst the local leadership team of the challenges and risks associated with the delivery of the emergency care pathway. However, there lacked an ability for the local leadership team to address the multiple challenges and areas for improvements which had previously been highlighted. Complying with regulatory imposed conditions had proved to be challenging with little evidence of change noted across a range of areas.

- In recognition of the need to enhance and support nursing leadership, four new band seven sister/charge nurse posts had been created across site. Staff told us many of the new roles had been successfully been recruited too, with some internal promotions from the existing workforce. Some staff reported the concept of internal promotion within the service which had experienced sustained challenges and lacked insight, was a potential missed opportunity for the organisation to assess how it plans and delivers care. That said, the increase of band six nursing staff and the appointment of four substantive consultants had all been considered as positive by staff we spoke with during the inspection as it afforded an opportunity for people to bring new ideas to the department, as well as potentially securing the future of the emergency department at The Princess Royal Hospital.
- We had previously reported frustrations amongst the workforce regarding the fact frontline staff did not feel they were listened too by senior members of the executive team. These frustrations remained present at this inspection. Visibility of trust leadership was reported to be poor. We noted the medical director was present in the emergency department on the day of the inspection. Local staff reported the medical director had been requested to attend the department because of the significant concerns local staff had over the safety and welfare of patients and so their presence was by exception rather than rule. Local staff reported site management teams poorly understood the emergency pathway. The focus for the trust was reported to be based on operational performance as compared to the safety and quality of services being the driving force. Staff gave examples of beds only becoming available and released by wards very shortly before named patients exceeding the twelve-hour decision to admit target. This was a standing challenge for the emergency department team as it suggested sustainable solutions were not being considered, with reactive practices commanding how the emergency care pathway was delivered.

Vision and strategy for this service

- As previously mentioned, the service had been subject to a formal public consultation to consider the future of clinical services across the region. Local staff alluded to some anxiety about the future of clinical services, however the appointment of new consultants and middle grade doctors, as well as a new recruitment campaign for nursing staff were all seen as positive indicators.
- Whilst the department was in a state of escalation during the inspection, there was little in the way of effective strategy to decompress and safely manage the emergency care pathway. There was a consensus amongst staff in the emergency department that the emergency care pathway was the responsibility of the emergency care team. This was perhaps most noticeable at the 4pm operational meeting in which representation was noted only from the nursing and operational team. There was no clinical representation, so it was unclear how speciality doctors were helping to support the emergency department. The concept of utilising community based beds appeared reactive as compared to be a proactive process. Despite asking various leaders across the organisation, we could get no response as to the support being provided by the wider health economy, in line with OPEL standards. The chief operating officer could describe the strategies to reduce length of stay as well as being proud of the trusts delayed transfer of care rate. However, there was little insight in to the operational and clinical pathways which could be optimised to sustainably support the emergency care pathway.

Governance, risk management and quality measurement

- The service maintained a risk register which recorded known risks and rated them according to their potential impact. The risk register reflected the risks spoken about by staff in the department. The risk register further acknowledged some of the challenges inspectors identified during the inspection. Risks across the emergency care pathway had been considered and

mitigating actions put in place for known issues. However, there remained risks for which mitigations were poorly thought through and implemented. Staffing and patient flow remained a focus as to the concerns and risks linked to the emergency pathway. Whilst senior executive leads could describe the wider system actions being taken, there was a lack of awareness in relation to timescales for completion of activities. Further, there lacked clarity as to who was responsible for the delivery of specific actions.

- The executive with responsibility for the delivery of the emergency pathway was poorly sighted on the risks associated with children and the lack of compliance against national service specifications for emergency care services for children. This meant there was extremely limited grip and the trust was unable to provide assurances as to how the standard of children's emergency services was going to be addressed in the future. Whilst staff reported concerns over the triage and streaming process, there again lacked any form of substantive plans to address those concerns, therefore generating a hiatus in the management of risk associated with the "Front door" pathway.
- Clinical governance meetings occurred monthly with good representation from the medical workforce. It was noted there was limited input from the nursing workforce and no representation from allied health professionals. Clinical governance meetings followed set agendas and included a review of incidents reported during the preceding month; infection prevention and control compliance; guidelines and patient information; safeguarding; risk register review; mortality and morbidity overview; patient experience; and patient safety case reviews. Serious incidents and an opportunity for any other business was also considered at the meeting. Senior staff were sighted on the challenges and risks associated with the department, however there remained gaps in terms of how such risks were being mitigated against.
- We were concerned over the lack of robust assurance associated with the information considered at the meetings. For example, at the March 2019 meeting, it was reported hand hygiene compliance was 100%; our observations during the inspection was that hand hygiene compliance was extremely poor with very little adherence to local and national best practice. Further, as we have discussed within the safe domain, compliance against EWS scoring protocols and the frequency of observations was not aligned to the trust policy. This was despite commentary within the March 2019 meeting minutes which stated, "Positive point - very robust now at doing repeat observations, even when overcrowded."

Culture within the service

- Staffing challenges continued to contribute to the low morale among the workforce. Working in challenging situation in which staff struggled to provide high quality care further compounded the challenges of the service. However, staff reported that whilst morale was low, it had improved since the last inspection in 2018. Staff reported positive outcomes regarding new posts being created; staff were realistic about the time it would take for new staff to take up posts however staff describe an appetite for change.
- A range of staff including doctors, nurses, support workers, administrative staff and representatives from the local NHS ambulance trust reported they could raise concerns to local the management team without fear of retribution. Staff told us they felt supported and were encouraged to be open and transparent. However, many staff reported receiving limited feedback from incidents and outcomes from morbidity and mortality reviews.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

As a result of this inspection, we opted to utilise our enforcement powers and imposed urgent conditions of the Provider's registration. Namely,

1. The registered provider must ensure that within three days of this notice, it reviews and implements an effective system with the aim of ensuring that all children who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines.
2. The registered provider must ensure that the staff required to implement the system as set out in the previous condition are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately.
3. The registered provider must ensure that the system makes provision for effective monitoring of the patient's pathway through the department from arrival.
4. The registered provider must provide the Commission with a report setting out the steps it has taken to implement the system as required in conditions two to three, within five days.
5. The registered provider must ensure there is a system in place which ensures that all children who leave the emergency department without being seen are followed up in a timely way by a competent healthcare professional.
6. From 26 April 2019 and on the Friday of each week thereafter, the registered provider shall report to the Care Quality Commission describing the system in place for effective management of children through the emergency care pathway. The report must also include the following:

a. The actions taken to ensure that the system is implemented and is effective.

b. Action taken to ensure the system is being audited monitored and continues to be followed.

c. The report should include results of any monitoring data and audits undertaken that provide assurance that a process is in place for the management of children requiring emergency care and treatment.

d. The report should include redacted information of all children who left the department without being seen; details of any follow-up and details of any harm arising through the result of the child leaving the department without being seen.

1. The registered provider must ensure that within three days of this notice, it implements an effective system with the aim of ensuring that all adults who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines.
2. The registered provider must ensure that the systems in place across the department can account for patient acuity and the location of patients at all times.

The trust must also ensure

They operate an effective clinical governance process which is supported by reliable and tested information and datasets.

Ensure staff receive feedback on incidents and outcomes from morbidity and mortality reviews.

Ensure staff comply with local hand hygiene and infection control protocols.

This section is primarily information for the provider

Enforcement actions

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	Section 31 HSCA Urgent procedure for suspension, variation etc. As a result of this inspection, we opted to utilise our enforcement powers and imposed urgent conditions of the Provider's registration. Namely, {cke_protected_1}1. The registered provider must ensure that within three days of this notice, it reviews and implements an effective system with the aim of ensuring that all children who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines. {cke_protected_2}2. The registered provider must ensure that the staff required to implement the system as set out in the previous condition are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately. {cke_protected_3}3. The registered provider must ensure that the system makes provision for effective monitoring of the patient's pathway through the department from arrival. {cke_protected_4}4. The registered provider must provide the Commission with a report setting out the steps it has taken to implement the system as required in conditions two to three, within five days. {cke_protected_5}5. The registered provider must ensure there is a system in place which ensures that all children who leave the emergency department without being seen are followed up in a timely way by a competent healthcare professional. {cke_protected_6}6. From 26 April 2019 and on the Friday of each week thereafter, the registered provider

Enforcement actions

shall report to the Care Quality Commission describing the system in place for effective management of children through the emergency care pathway. The report must also include the following:

a. The actions taken to ensure that the system is implemented and is effective.

b. Action taken to ensure the system is being audited monitored and continues to be followed.

c. The report should include results of any monitoring data and audits undertaken that provide assurance that a process is in place for the management of children requiring emergency care and treatment.

d. The report should include redacted information of all children who left the department without being seen; details of any follow-up and details of any harm arising through the result of the child leaving the department without being seen.

{cke_protected_7}7. The registered provider must ensure that within three days of this notice, it implements an effective system with the aim of ensuring that all adults who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines.

The registered provider must ensure that the systems in place across the department can account for patient acuity and the location of patients at all times.