The Princess Royal Hospital

Quality Report

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Date of inspection visit: 18 February 2020
Date of publication: 08/04/2020

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at Princess Royal Hospital on 18 February 2020, in response to concerning information we had received in relation to care of patients in this department.

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. We also undertook an unannounced inspection of the emergency department at Royal Shrewsbury Hospital on 17 February 2020 which has been reported separately.

During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry however we have rated this service in accordance with our enforcement policy.

This was a focused inspection to review concerns relating to the emergency department. It took place between 10am and 4pm on Tuesday 18 February 2020.

We found:

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

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment. However, staffing gaps were filled with temporary bank and agency staff.

The service did not have enough permanent medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.

Leaders did not have the skills and abilities to run the service in a safe and effective manner. Leaders did not understand and manage the priorities and issues the service faced. Senior leaders were not always visible and approachable in the service for patients and staff.

The service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action. However, senior leaders engaged with stakeholders regarding the planning of future ED services.

Leaders in the ED did not operate effective governance processes throughout the service. The service did not always identify, escalate and mitigate relevant risks and issues.

Staff did not always feel respected, supported and valued by the senior executive team.

Importantly, the trust must:

Action the hospital MUST take to improve

Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable.

Summary of findings

Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children.

Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales.

Ensure care records are always readily available.

Ensure patients can access care and treatment in a timely way.

Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway.

Ensure patients are treated with dignity and their privacy is always protected .

Ensure patients are managed in an environment which is fit for purpose.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to The Princess Royal Hospital

We carried out an unannounced focused inspection of the emergency department at Princess Royal Hospital in response to concerning information we had received in relation to care of patients in this department.

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; however, we have rated this service in accordance with our enforcement policy.

We previously inspected the emergency department at Princess Royal Hospital in November 2019. We rated it as inadequate overall. Following this inspection, we initially considered using our urgent enforcement powers due to significant concerns we had over the health and safety of patients in the department. In accordance with guidance issued by the National Quality Board (NQB) and in response to our concerns, system wide risk summits were held on 13 December 2019, 21 January 2020 and 25 February 2020. Risk summits provide a mechanism for key stakeholders involved in the system-wide delivery of health and/or social care to come together to share and review information when a serious concern about the quality of care has been raised. Risk summits enable those organisations to facilitate rapid, collective judgements about the quality of a service and to agree actions needed because of the risks identified.

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford.

- The trust has 721 acute beds (+9% from June 18), 22 critical care beds (+5% from June 18) and 37 maternity beds (0% change).
- From March 2018 to February 2019, there were 123,851 inpatient admissions (+8% compared to previous year). 9,068 of these were children, approximately 8.6% of all admissions.
- There were 718,882 outpatient attendances (+12% from previous year).
- There were 121,442 accident and emergency department attendances (+9% from previous year).

The trust employs 5,108 WTE staff.

Our inspection team

The team that inspected the service comprised of 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 Bernadette Hanney, Head of Hospital Inspection.

Inadequate

Urgent and emergency services

Safe	Inadequate
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate

Information about the service

The emergency department (ED) at Princess Royal Hospital (PRH) provides services 24-hours per day, seven days per week service. The Princess Royal Hospital is the main receiving centre for the acutely unwell child.

The ED at PRH consists of:

- A booking in and streaming area. Streaming at this ED involved identifying if a patient required assessment and treatment within the ED or within the urgent care centre which was operated by another provider on site.
- A main waiting area.
- A children's waiting area for those aged under 13 years.
- One triage room
- A four bedded resuscitation bay.
- Eight majors' cubicles. Patients who were referred to this area of care could be unstable in their presentation, unable to mobilise and require immediate treatment or medication
- A four bed 'pit stop'. This is where most patients who attended the department by ambulance received their initial assessment.
- A clinical decision unit (CDU) that could accommodate up to two patients in separate side rooms plus additional space for patients well enough bot to require a trolley. The CDU operated limited hours, opening at 10.30am and closing at 10pm.
- Four minors' cubicles providing care to patients who presented with minor injuries.
- A fit to sit area
- A children's assessment and treatment cubicle
- A "Pit stop" or rapid assessment area for patients arriving by ambulance, or for those patients who self-presented to the ED who were prioritised by nursing staff.

There was also an urgent care centre located adjacent to the main waiting area. This was managed separately by another provider and therefore did not form part of this inspection.

During the inspection, we visited the emergency department only. We spoke with 17 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with 11 patients and four relatives. During our inspection, we reviewed 33 sets of patient records.

Are urgent and emergency services safe?

Inadequate

Environment and equipment

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

- 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 department consisted of a major's unit as well as a minor's injuries unit and a clinical decision unit along with a supported commissioned urgent care centre. The layout of ED comprised of a main waiting area, and a separate waiting area for children under the age of 13 years old. Infants and children were only directed to the separate waiting area once they had been seen by the triage nurse. This resulted in periods of time when children were required to wait alongside adults. Within the main waiting 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, be it minors,

majors, resuscitation or urgent care. A triage room led off the main waiting room. Within the treatment areas there were four 'minors' cubicles for patients with minor injuries or illness and one paediatric cubicle. Eight 'major' cubicles for those patients with major illness or injury and a paediatric treatment room. In addition, there were three 'pit stop' cubicles where rapid assessments were carried out following triage, and two cubicles for fit to sit with a chair and another with a trolley. The resuscitation area comprised a large room with four open bays and one of which was designed for paediatric patients. A clinical decision unit, which had two bedded cubicles and two cubicles for seated patients. The CDU operated Monday to Sunday from 10.30am to 10pm at night.

- The design of the environment did not follow national guidance. For example, national guidance aimed at providing a safe environment for children presenting at an ED was not being followed. The environment standards set out in the June 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings was also not being followed. Children waiting to be seen by the triage nurse were required to wait in the main adult waiting area. During periods of peak activity, nursing staff reported it was not unusual for children to wait up to one hour before being seen by the triage nurse, and then subsequently directed to the separate waiting area. Additionally, nursing staff reported they actively enforced the local policy that the waiting room was only for use for those aged under 13 years of age. This was contrary to national standards which identifies children as anyone under the age of 18. Whilst it is common practice for those aged 16-17 to be given a choice as to where they would wish to wait to be seen or treated, we noted the local age policy was discriminatory to those aged under 16 years of age. Further, those aged 13 to 16 who were required to wait in the main adult waiting room were likely to be in a position whereby they were exposed to other patients who presented with challenging behaviours, or those who were intoxicated or under the influence of illegal substances for example.
- National guidance relating to provision of a safe environment for patients presenting at the ED with acute mental health concerns had improved. At our previous inspection, the trust was in the process of adapting a room which complied with the July 2017 Royal College of Emergency Medicine, Best Practice Guideline: Emergency Department Care standards which recommends that ED's provide a dedicated psychiatric assessment room that conforms to Psychiatric Liaison Accreditation Network (PLAN) standards. At the time of our inspection, a new room had recently been completed. The room had two means of exit; doors were fitted with anti-ligature handles and anti-barricade frames allowing for staff to remove the door in the event of an emergency; emergency alarms had been fitted through the room; doors had privacy glass to allow for discrete observation of patients and lighting was adjustable to allow patients to get rest. However, there were several pieces of furniture in the room which did not meet national standards as they could be used as a missile including a lightweight general waste bin and chairs. Air ventilation shafts were present in the room, suggestive of pipework being present above the false, non-secured ceiling tiles; such pipework and other ancillary equipment posed ligature risks.
- Access to the majors ED from the main waiting area was via secure access. There were elements of the ED which were not as secure, such as via the x-ray department. There was however the ability for ED staff to "Lock-down" the ED as required.
- Because of bed capacity challenges at the trust, patients were regularly and routinely cared for in the ED corridors. Corridors were relatively wide however patients were mainly cared for on assessment trolleys to reduce the risk of corridors becoming too narrow for patients to be transferred, or in the event a major unplanned evacuation was required. However, patients did not always have access to call bells to alert staff in the event they required assistance. Patients located on trolleys and chairs in the corridors did not have access to call bells. We spoke with three patients who were being cared for along the corridor. They reported they relied on waiting for a member of staff to pass by or had to ask a relative or call out for help. This meant there was an inherent risk in that those patients who may feel acutely unwell or who were at risk of rapidly deteriorating, may not be able to call for immediate help.

Inadequate

Urgent and emergency services

Assessing and responding to patient risk

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.

- National guidance relating to the initial assessment of patients who presented at the ED was not always followed. The February 2017 Royal College of Emergency Medicine Initial Assessment of Emergency Department Patients states that patients should be triaged within 15 minutes of arrival. Triage is a face-to-face contact with a patient to prioritise their need for further assessment and treatment in a system where the demand for patient care outstrips the ability of the system to deliver it at the time of presentation. A triage and streaming system were in place that aimed to prioritise patients, so they could receive the right care at the right time in the right place. After booking in at reception, patients were redirected to the "Yellow zone" before being called to a second window to speak with the streaming nurse. The streaming nurse asked clinical questions and identified patients who could be seen at the urgent care centre (another service based on site but managed by another provider). They also allocated patients to a triage queue or directed patients straight to resus if they had very urgent care needs. Following concerns identified at previous inspections, we imposed regulatory conditions of the trusts' registration which required them to operate an effective triage process. This was to enable better awareness among staff as to the clinical acuity of patients who self-presented to the department.

- The trust was legally required to submit information on a routine basis detailing how they were meeting these conditions and to explore any potential harm caused to patients who may not have been initially assessed within a timely way. We used this information as a means of gaining assurance that patients were being clinically assessed within an appropriate timeframe. However, we noted during an inspection of the service in November 2019 that there was ambiguity as to the time being recorded on the patient's CAS card, which was used by local leaders to compile the section 31 returns. Staff reported that once a patient had seen the streaming nurse, this time was recorded on the CAS card. However, due to the nature of the mixed streaming/triage process used in the department, the streaming nurse was not able to clinically assess a patient as they had no location to undertake vital sign observations to facilitate an appropriate triage assessment. Whilst those patients who looked extremely unwell could be expediated to majors, or to the resuscitation room, those patients who presented with mild symptoms of chest pain, or had underlying deranged vital signs for example, may not have been so easily detected, especially if a patient was in a clinically compensated state. The body has inherent survival mechanisms which are triggered during periods of critical illness for example. These processes are often only sustainable for short periods of time, and once exhausted, the body succumbs to the symptoms of the underlying illness. This compensatory mechanism can initially mask the actual acuity of a patient and can mislead health professionals if the underlying cause is not quickly identified, resulting in patients rapidly deteriorating. The trust subsequently reported they only monitored the time it took from patients booking in to being streamed, rather than the time from booking in to triage. Trust data showed the average time to streaming between August 2018 and October 2019 was 20.5 minutes. This meant the trust was consistently not meeting the 15-minute triage standard for adults. Additionally, because patients experienced an initial delay in being triaged, the resulting impact was an increasing wait to also be seen by a senior clinical decision maker and a plan of care commenced. On 17 February 2020 we observed there to be limited numbers of patients self-presenting to the emergency department. This meant patients experienced minimal waits between booking in with reception staff and being seen by the streaming nurse. However, despite there being minimal activity on the day of the inspection, there were still periods of time when patients waited more than 15 minutes even to be seen by the streaming nurse, despite there being no other patients in the streaming queue. This raised a query over the productivity of the streaming nurse as there was no apparent reason for patients waiting extended periods of time between booking in and being streamed.

- During the inspection we observed the streaming and triage process and whilst there were minimal waits for

patients to be seen by the streaming nurse, patients referred to be seen by the triage nurse often waited periods of 20 minutes of more before they had a set of observations were completed; this was despite the waiting room being relatively quiet on the day of the inspection. However, nursing staff reported that during peak times, it was not uncommon for patients to wait up to an hour between being streamed and being seen by the triage nurse. This suggested that when busy, patients could expect to wait extended periods of time before nursing staff could ascertain a baseline for the patient, to aid the developing an appropriate triage protocol.

- We had previously raised concerns that patients arriving by ambulance were often delayed in being clinically assessed and handed over. This meant there was a risk acutely unwell patients may not have received time critical care and treatment. To address ongoing challenges, the trust had previously created a clinical pit-stop area as part of a rapid improvement project. This area was used to allow for patients arriving by ambulance (and on occasion, patients who self-presented who appeared extremely sick) to be rapidly assessed by a senior nurse. During this inspection, we observed this process working well. Patients were received, in general, in a timely way by the pitstop nurse. Clinical interventions including electrocardiograms (ECGs), blood tests and other assessments were carried out quickly and routinely within 15 minutes. We observed instances when the nurse was sufficiently concerned about the condition of a patient and subsequently escalated the patient to medical staff who then carried out timely assessments of patients.
- In the period leading up to and during Christmas 2019, the hospital was experiencing high numbers of ambulances which were delayed by more than 60 minutes from arrival to handing over patients. Data shows peaks and troughs in the number of ambulances delayed during this time ranging from five to 28 ambulances each day. There was then sustained improvement between 15 January 2020 and 29 January when fewer than five ambulances were delayed daily. Peaks in activity were then noted thereafter with up to 15 ambulances delayed by more than 60 mins, daily. During the inspection, ambulances were offloaded, and patients handed over in a timely way. However, staff reported that there were occasions when ambulances were required to cohort their patients, or experienced delays in handing their patients over. We asked staff to describe the process for providing clinical oversight and to outline the assessment pathways for patients who were cohorted and who could not be handed over. We were told there was currently no standard operating procedure for the oversight of the ambulance queue. Nursing and medical staff reported they would not routinely review those patients in the ambulance queue unless a paramedic or technician were concerned about the patient and therefore escalated their concerns to the nurse in charge. This presented a significant clinical risk and was contrary to national guidance issued by NHS Improvement in 2017 ("Addressing ambulance handover delays: actions for local accident and emergency delivery boards"). This mandates that "The patient is the responsibility of the ED from the moment the ambulance arrives outside the ED, regardless of the exact location of the ambulance".
- Although nursing staff had access to nationally recognised risk assessment tools including the national early warning scoring system (NEWS2), Waterlow skin risk assessment tools and sepsis six care bundles, compliance with the applications of these tools was varied. The national early warning score (NEWS2) and the paediatric early warning score (PEWS) were designed to help clinical staff to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). Whilst staff were commencing sepsis screening tools for patients, they did not consistently follow trust protocols. For example, staff routinely identified patients as being at low risk of sepsis despite patients having recorded early warning scores of two in single parameters. The trust policy requires staff to proceed with the flow chart where patients have a single parameter scoring two or more.
- There was sporadic use of the NEWS2 tool. Where patients had met the criteria for hourly monitoring, as part of the NEWS2 escalation and management protocol, there was sporadic compliance noted from the comprehensive review of the clinical notes we considered during the inspection.
- Patients identified as being at high risk of pressure damage through Waterlow skin assessments, remained

on trolleys for extended periods of time with no active mitigations. This included one elderly patient who had been recognised as being at very high risk of skin damage remaining on an assessment trolley for 15 hours. Nursing documentation was poor and did not describe the routine skin care provided to this patient. This was contrary to national guidance which states: The National Institute for Health and Care Excellence, Clinical Guideline 179: Pressure ulcers: prevention and management recommend that patients identified as being at "High risk" should be supported to be repositioned every four hours and that the frequency of repositioning should be recorded.

- A second patient had also been identified as being at very high risk of skin damage, with a Waterlow score of 21. Again, this patient remained on an assessment trolley with no additional protective measures in place for a period of 17 hours. There was no routine documentation to demonstrate how nursing staff had met the needs of the patient through regular repositioning and skin care being provided. A third patient was in significant back pain and despite having complained about their discomfort whilst awaiting transfer to another service, there had been no efforts made to transfer the patient to a more comfortable bed. The patient had been in the department for more than 12 hours.
- Care records were often incomplete and, in some cases, missing altogether. This included one patient who had initially presented to the department in significant abdominal pain. Despite the patient waiting for approximately one hour and fifty minutes between being triaged and being called to be seen by a doctor no analgesia was offered to the patient. We opted to case track the patient through their journey however when we asked to see the notes of the patient in the afternoon nursing staff could not locate them and could not recall the outcome for the patient. Of the ten sets of paediatric notes reviewed, three did not contain any written record of any clinical assessment or treatment plan by doctors. Nursing staff reported that medical staff would often use a paediatric proforma but that these should be stored with the clinical notes; no such proforma was found despite the children having received clinical interventions such as medicines being prescribed for the management of asthma as an example. We raised this with nursing staff who reported it was not uncommon for CAS cards to be missing. This was further supported by reception staff who were responsible for the CAS cards once patients had been discharged. They reported that doctors may take the CAS cards, or they may have accidentally been sent to the ward. This meant that should a patient reattend, there was no clinical written record available to clinical staff detailing previous treatments or clinical interventions or treatment plans. This introduced a level of inherent risk to patients for which there was currently no robust action plan to resolve in the interim until a full electronic patient record system was introduced in to the ED in May 2020.
- Local policies required patients who presented with chest pain to have an electrocardiogram within a defined period. We reviewed some 34 sets of notes during the inspection and found that on six occasions when an ECG was clinically indicated, patients waited for periods of one hour or more before receiving their first ECG. This meant there was a risk to patients of not receiving time critical treatment in the event they presented with acute coronary syndromes or other time critical conditions.

Nursing staffing

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment. However, staffing gaps were filled with temporary bank and agency staff.

- The service did not have had enough permanent nursing staff to keep patients safe. There was a very high reliance on temporary bank and agency staff. This was observed to be the case during the inspection. We spoke with four agency nurses, some of whom had been allocated a set block of shifts to support the ED. Each agency nurse reported they were familiar with the department. They could describe the actions they would take in the event a patient deteriorated, including the use of the NEWS2 system, as well as being able to identify the location of resuscitation trolleys. Although agency staff did not have access to electronic systems, therefore hindering their ability to view x-ray reports for example, each agency nurse could describe who they would liaise with to gain access.

- Local leaders reported they had completed a baseline staffing assessment to determine the numbers of nursing and health support workers required to safely manage the department. It was reported this assessment was carried out using the Royal College of Emergency Medicine Baseline Emergency Staffing Tool (BEST). Because of the assessment, 16 nurses were deployed for each day shift. Nursing staff considered this to be enough nurses to meet the needs of patients when the department was at capacity. There were concerns raised that 16 nurses were not enough however when the department was above capacity. It was reported that on 17 February (the day prior to our inspection), clinical need required there to be five patients in the resuscitation area; nursing staff reported that this placed additional burden on the nurse assigned to the resuscitation room, although they acknowledged an additional member of staff had been allocated to support them.
- During the inspection we observed the clinical decision unit to be staffed at all times.
- The trust reported they required 14 band seven nurses, 63 band six, 53 band five and two practice development nurses to safely staff both emergency departments. At the time of the inspection, there were four vacant band seven posts (29% vacancy rate); 23 band six posts (36.5% vacancy rate), 39 band five posts (73.5% vacancy rate) and both practice development roles were also vacant (100% vacancy rate). The trust reported adverts for the band seven roles had attracted 11 applications with ten individuals shortlisted for interview. 12 applications had been received for the band six roles with nine individuals shortlisted for interview. Eight individuals were shortlisted for interview on 27 February 2020.
- The trust reported they were undertaking an extensive overseas nurse recruitment campaign directed at closing the high band five vacancy gap. Six nurses had arrived in to the UK on 5 December 2019 who were shortly followed with an additional 48 nurses. Six nurses had undertaken their observational scenario clinical examinations to enable them relevant registration with the Nursing and Midwifery Council, and therefore the legal ability to work in the UK as a nurse. A further nine nurses were scheduled to undertake the OSCEs on 14 February 2020. The trust anticipated that by May 2020, 106 overseas nurses would have arrived. A further overseas pipeline of OSCE ready nurses had recently been interviewed from which 28 had been identified as being suitably competent to work in the emergency departments across the trust.
- As at December 2019, the trust reported that of the 9,958 total nursing care hours required to provide care and treatment, 519 hours had remained unfilled. Despite the use of temporary staffing, this meant the department remained understaffed by 3.1 whole time equivalent nurses through December 2019.
- In total, 52% of care hours were covered through temporary staffing arrangements, 5% of care hours were unfilled, and 43% were covered through substantive staffing arrangements. 26% of care hours in December were covered through block-booked agency staff; 18% through adhoc agency and 8% supported through bank staff cover.
- The trust did not have enough children's nurses to meet the June 2018 Royal College of Paediatrics and Child Health guidance, Facing the Future: Standards for children in emergency care settings. There were not enough children's nurses employed by the trust to ensure two children's nurses were available on each shift. An ongoing recruitment programme was in place to try and address this. The Care Quality Commission recognises the challenges of recruiting enough numbers of qualified and competent children's nurses to provide continuous emergency care services which meet the RCPCH standards. This is also recognised as a challenge within the standards themselves. However, providers must ensure they recruit and deploy enough numbers of staff with the right skills, training and competency to provide safe and effective care. The standards state that providers should ensure that where there are recruitment challenges, it is essential that a flexible workforce is developed whereby staff are competent and safe to care for infants, children and adults and that this should include emergency care skills.
- We asked local leaders whether adult nursing staff had received any additional training or completed recognised competency frameworks to help them to care for infants, children and young people. We were informed that no such competency framework existed at the trust. We raised this as a significant area of concern with the trust executive team. They subsequently reported they were acting to ensure there

were enough numbers of nursing staff each shift to meet the needs of children. We continue to monitor this closely with the trust and system partners and will take appropriate action if we identify further concerns.

Medical staffing

The service did not have enough permanent medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- The service did not have had enough permanent medical staff to keep patients safe. There was a very high reliance on agency and locum staff. The trust was commissioned to provide type one and type two emergency care services across two acute locations, Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. At the time of the inspection, the trust employed six whole time equivalent consultants against an anticipated establishment of 20. However, because of long term sickness and maternity leave, only four consultants were available across the two emergency departments to provide consultant presence.
- There was a rolling advert for emergency care consultants, and also a long term plan for the trust to recruit suitable individuals to gain their certificate of eligibility for specialist registration (CESR) (a General Medical Council initiative which supports doctors to register as a consultant, first having joined a specialist registrar, when individuals have either trained in non-approved posts or they have entered an approved training post at a later starting point and completed the rest of the programme and gained the remaining competencies).
- An interview had been scheduled for 24 February 2020 for one candidate for the role of substantive consultant.
- The department was supported by four further locum ED consultants who had been booked until at least March 2020; a further one locum consultant was scheduled to start with the trust on 26 March 2020.
- The trust did not have a Paediatric Emergency Medicine (PEM) consultant as recommended in the June 2018 RCPCH guidance, Facing the Future: Standards for children in emergency care settings.
- The trust did not meet the Royal College of Emergency Medicine (RCEM) Workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK which state a consultant should be present in the ED for a minimum of 16 hours a day (8:00am – 00:00am). At Princess Royal Hospital, consultants worked in the ED Monday to Friday between 8:00am and 10:00pm and 9:00am and 3:00pm at weekends. On call consultant cover was provided at all other times.
- The trust required 32 middle grade doctors to support the emergency care departments across both hospitals. At the time of the inspection, the trust had 14 fully competent middle grade doctors and an additional ten who were supernumerary. The trust anticipated that by June 2020, there would 18 fully competent middle-grades, with an additional twenty supernumerary doctors, totalling 38. These projections were based on successful overseas recruitment campaigns. Overseas recruits had been supported with relocating to the UK including support in sourcing accommodation, English language development courses and support from the consultant body. Each recruit was to be allocated a named consultant responsible for induction, clinical development and pastoral care.
- There were 28 junior doctors working across the two emergency departments. The trust projected that, to facilitate an increase in activity to 130,000 attendances annually, 36 junior doctors were required to safely staff the emergency departments. It was reported a business case was in the process of being finalised to secure the required increase in junior doctors.
- Senior doctors reported significant concerns that it was difficult to co-ordinate the department safely and effectively whilst also undertaking other activities such as clinical governance responsibilities, mortality and morbidity reviews and participate in audit programmes.

Inadequate

Urgent and emergency services

Are urgent and emergency services caring?

Requires improvement

Compassionate care

The service was not designed or delivered in a manner that respected patients' privacy and dignity. Staff did not always have the time to interact with people in a meaningful way.

- Due to the congestion within the department, there were many 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. Staff told us that patients were transferred to a bay in the clinical decision unit (CDU) within the department if personal care was required for immobile patients. There were occasions during the inspection when clinical interventions such as phlebotomy (blood taking) was undertaken in the corridor due to the CDU being full.
- Staff did not always respect patient's privacy and dignity while they were in the department. Patients dignity was not always observed within the waiting room. Conversations between the streaming nurse and patients could be easily overheard by other patients, thus infringing on patient confidentiality. This had previously been raised as an area of concern however it was felt by nursing staff that the practice had been normalised. Nursing staff were keen to change the streaming process however they did not feel they had the autonomy to do so.
- Senior staff reported the CDU closed at 10pm each night and reopened at 10.30 the following morning. On our arrival we noted three patients, including two frail elderly patients, had been nursed on assessment trolleys in the corridor all night despite there being side rooms available in the CDU. We raised this with senior leaders who had not considered the individual needs of patients. There was a significant resistance to accommodating patients overnight in the CDU overnight, with the standard operating model in the ED being one in which patients would be managed on the corridor. This was not conducive to the privacy and dignity of patients, nor was it a positive experience for patients.

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

Inadequate

Access and flow

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.

- The trust used 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 hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care. The trust executive reported the system as being on OPEL two at the time of the inspection. National criteria define OPEL two as "Four-hour access target being at risk of compromise; the local health and social care system is starting to show signs of pressure. The local accident and emergency delivery board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation". Further examples of OPEL two within the national framework are described as "Anticipated pressure in facilitating ambulance handovers; insufficient discharges to create capacity for the expected elective and emergency activity; opening of escalation beds likely; infection control issues emerging; lack of beds across the trust; ED patients with Decision

to admit and no action plan". OPEL three is described as "Four-hour access target significantly compromised; significant numbers of handover delays; patient flow significantly compromised".

- An escalation process was in place to enable ED staff to monitor and escalate access and flow problems within the ED. However, staff told us this tool was not always used in line with local guidance due to capacity issues and other pressures within the department. This meant acute changes in access and flow may not always be escalated in a prompt and effective manner. Further, local leaders did not feel the escalation protocol led to any noticeable improvement in terms of resolving patient flow in the department. Executive visibility in the ED was reported to be poor.

Median time from arrival to treatment (all patients)

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust consistently failed to meet the standard and performed worse than the England average over the 12-month period from August 2018 to July 2019. The percentage of patients who were seen and treated by a senior clinical decision maker within 60 minutes from arrival between 23 December 2019 and 2 February 2020 was reported as 24.2%. This was significantly worse than the England average between the same time period.
- The average time to treatment was reported as 111 minutes for November 2019. This had increased from 94 minutes when compared to November 2018.

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

- In December 2019, a total of 348 patients waited between more than 12 hours from the decision to be admitted being made, to the patient being transferred to a bed, compared to one patient in December 2018.
- Patients could not always access inpatient care from the ED in a timely manner, which meant this patient cohort stayed in the ED for longer than they should have. The trust did not consistently record and monitor the numbers of patients in receipt of corridor care.

Percentage of patients admitted, discharged or transferred within four hours from arrival

- The Department of Health and Social Care 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 September 2018 to August 2019 the trust consistently failed to meet the standard, and consistently performed worse than the England average.
- The percentage of patients who were admitted, discharged or transferred within four hours from arrival between 23 December 2019 and 2 February 2020 was 70% (includes type 1, type 2 and type 3 cases) (6 week average). Trust wide, for the duration of December 2019, performance against this metric (for all attendance types) was reported as 68.1% which was worse than the data reported for December 2018 (65.5%)
- The percentage of patients who met the “Majors” criteria who spent less than four hours in the emergency department in December 2019 was 57.9%. This was worse than the trusts previous performance for December 2018 which was reported as 58.4%.

Are urgent and emergency services well-led?

Inadequate

Leadership

Leaders did not have the skills and abilities to run the service in a safe and effective manner. Leaders did not understand and manage the priorities and issues the service faced. Senior leaders were not always visible and approachable in the service for patients and staff.

- Despite the Care Quality Commission having previously inspected and reported against the full key lines of enquiry, as set out in published standards, which detailed the necessary areas for improvement, there remained a significant and profound lack of progress to address longstanding concerns within the department, and wider emergency care pathway. Local leaders did not recognise the serious shortfalls in the quality of care provided in their emergency department. There was a lack of situational awareness, further hampered by poor governance and risk management processes.

Inadequate

Urgent and emergency services

- Despite their being a visible presence of leaders in the department, there was a generalised acceptance and blindness to the substandard level of care provided to frail patients. This included a general acceptance of nursing high risk patients on trolleys for extended periods of time. Nursing staff of all grades considered that due to the design of the mattresses, frail, high risk patients could remain on assessment trolleys for periods of up to 16 hours without there being any tissue damage. This contradicted national best practice guidance which requires that alongside mechanical interventions such as the use of pressure relieving devices, patients at risk of skin damage should also be regularly repositioned and that records of care are maintained to support this. These interventions were absent during the inspection and had not been challenged by senior clinical leaders. Further, nursing staff had not considered the wider implications of patients being nursed for extended periods on trolleys; this included the generalised discomfort associated with the narrow nature of the trolley as an example.
- The local leadership team reported that shortfalls in the consultant workforce had contributed to a lack of change of culture in the department. Further, workforce challenges meant there was limited ability to change governance processes in order there was enough reporting of issues to effect systemwide change.
- Staff reported a sense of isolation and exclusion from the executive team who were "dismissive" of the challenges faced in the emergency department. The lack of robust safety metrics and elements of false assurance perhaps contributed to the perceived lack of seriousness or impact faced by the emergency team and associated care provided. Anecdotally, we were told that on the 17 February 2020 the department had 108 patients with five patients being managed in the resuscitation room. 15 patients were waiting for extended periods with ambulance crews due to the pit stop area being full. Whilst a senior staff member raised concerns with the executive team, it was reported there was no formal or robust response, other than being informed there was no in-patient capacity in the trust. This left staff feeling demoralised and dismissed despite them having safety concerns.
- The trust operated two major emergency departments which were managed and overseen by a clinical director. At the time of the inspection, the long-standing clinical director was absent on a period of extended leave resulting in another consultant acting-up in to the role. The role of clinical director was being advertised internally, for which we were told there were two existing members of staff who were interested in applying. However, what was apparent through the inspection was the wilful lack of engagement between the consultant parties across the two emergency departments. There was an element of stubborn behaviour displayed by individual members of the team which added to the lack of progress made across the emergency departments. Staff reported concerns that in the event of an internal appointment being made, there would continue to be a lack of progress on one site over another due to a perceived lack of engagement from consultants at the ED for which they did not work at.
- The nursing leadership team advocated for cross site working with some members of the team undertaking rotational posts across the two emergency departments to help better understand the variations in the quality of services. Six-month rotation programmes had been established for the band seven cohort. These individuals spoke candidly about the variations with the team at Princess Royal Hospital where staff considered the team there to be more forward-thinking, innovative and demonstrating a wanting to change the status quo.
- Operational nursing leadership at a local level was poor. There was a lack of escalation to more senior trust executive team members where there had been identified and continuing omissions in care. Nursing staff were not acting as advocates for patients as mandated by the Nursing and Midwifery Council Code of Practice which states that all registrants must "Put the interests of people using or needing nursing of midwifery care first… make their care and safety your main concern and make sure that their dignity is preserved, and their needs are recognised, assessed and responded to". Nursing and medical staff were not consistently reporting incidents to help improve care and to learn from when things had gone wrong. In addition, extended waits on assessment trolleys, omissions in administering routine medicines, poor compliance with sepsis care bundles and a failure to meet the individual needs of patients were all suggested of institutional failings.

Inadequate

Urgent and emergency services

Vision and strategy for this service

The service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action. However, senior leaders engaged with stakeholders regarding the planning of future ED services.

- There was no specific vision and strategy specifically dedicated to urgent and emergency care services at the trust. Staff spoke of a departmental philosophy which was orientated towards placing the patient at the centre of the service. However, our findings of this inspection, married with previous inspection findings suggested there was little commitment to the departmental philosophy.
- The trust reported the emergency divisional care group continued to work with system-wide partners including representatives from the Emergency Care Intensive Support Team (ECIST) and NHS Improvement to develop a clear vision and strategy for both the intermediate and long term.
- Departmental leaders spoke of addressing longstanding workforce challenges, as well as having a department which was fit for purpose as the two most pressing concerns which were impacting on the overall quality of the service. Whilst the trust had introduced same day emergency care models for ambulatory patients, as well as establishing an acute medical assessment unit, the service operated a very traditional emergency care model. Frailty pathways had not been fully considered despite there being a national mandate. A lack of capacity for the local team to take time away from clinical duties to focus on wider system improvement plans had been given as the reasons for a lack of robust vision or strategy. Changes and interim appointments to the executive team were also cited as an obstacle to the change agenda.
- Consultants reported feeling disconnected from the executive team in terms of the development of a robust emergency care strategy. The team reported they had not been included in discussions regarding clinical pathways or new models of care.

Governance, risk management and quality measurement

Leaders in the emergency department did not operate effective governance processes throughout the service. The service did not always identify, escalate and mitigate relevant risks and issues.

- Departmental governance and risk management strategies were ineffective and were not sufficiently resourced to ensure local leaders were aware of, and therefore assured by the quality of services provided. An on-going commitment to undertake regulatory imposed evidence returns, a lack of substantive workforce and a lack of capability within the local team were all citied as contributory factors, which further hampered the development of robust governance processes.
- Local leaders were not fully sighted on the risks associated with the department. There was a reactive attitude to risk management, likely because of there being insufficient dedicated time afforded to the right people with the right skills to undertake robust reviews of governance and quality metrics within the department.
- There was a lack of capacity for the local team to undertake a fresh perspective of the overall quality of care being provided. Some staff had only ever worked at Royal Shrewsbury Hospital and so lacked the insight in to how emergency care and associated care models had progressed over time. Rotational programmes were reported as being well received by senior nurses as it had afforded them an insight in to another emergency department.
- Although cross-site governance meetings took place monthly, there was limited evidence of change because of these meetings. Some referred to the governance meeting as being a “tick-box exercise” which “afforded no real change”. Incidents, complaints and regulatory conditions were considered as part of the governance process however, in reality, there remained little change to practice. Serious incidents had been discussed however actions identified were often lack-lustre and insufficient to drive improvements. This included a serious incident in December 2019 when a patient’s presenting complaint was not effectively managed. Routine physical observations had not been carried out on the patient in the lead-up to their cardiac arrest. Our review of NEWS2 charts continued to show sporadic

compliance with the NEWS2 frequency rules. There was limited evidence in medical and nursing notes of when patients had been escalated in response to an increase in NEWS2 scores. Further, we noted one example where there had been evidence of nursing staff escalating their concerns to the medical registrar on three occasions however there had been no response. The patient was subsequently transferred to the coronary care unit for on-going management instead of waiting for the medical registrar to review the patient in the ED. These were all examples of where there had been a lack of robust governance processes to underpin changes to practice across the emergency department.

- There had been a lack of progress to upskill nursing staff to ensure they were competent to manage children and young people.
- Senior leaders in the department had little awareness of the risks associated with the emergency care service. There was limited insight in to the risks which were captured on the departmental risk register. Senior leaders afforded differing views as to the risks of the department. Whilst medical and nursing staffing were referenced and indeed included as departmental risks, there was limited insight in to the lack of children's nurses. There was limited insight from local leaders in to how nursing establishments had been calculated, which meant little assurance could be taken from the ratio of nurses deployed each shift versus the needs of patients accessing the service. The trust executive team however reported that staffing establishments had been calculated with the support of ECIST, using their recognised staffing model. This assessment was submitted to the public board in May 2019 and included a rationale for the staffing numbers and details of the model used and how the establishment was reached.
- Others described consultant recruitment, the clinical decision unit not being fit for purpose, emergency care exit blocks (including a need to increase the number of nurses deployed to meet the needs of patients as well as an increase in demand), a focus on improving performance against constitutional standards and a requirement for speciality teams to accept responsibility for their patients, were all considered as risks. The wider aspect of quality of care within the department; compliance with trust protocols and practices and at a more basic level, the delivery of fundamental care standards was not seen as risks associated with the ED.

Culture within the service

Staff did not always feel respected, supported and valued.

- Staff reported low morale across the department. A feeling of disconnect from the wider trust and executive team were both common themes when speaking with staff about morale. Some senior nursing staff did not feel empowered to make change, in part associated with allegations of bullying from more senior members of staff. However, at a local level, staff reported they worked well as a team. Individuals felt they could rely on other members of the emergency care team, even during periods of high demand. Staff spoke positively about the rapid improvement projects which had taken place, including the introduction of the pit-stop area. Although staff said they were encouraged to report incidents, time constraints were cited as reasons for not always doing so, meaning there was the potential for missed opportunities to learn and enhance patient safety in the department.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children. Regulation 18(1)(2)(a)

Ensure care records are always readily available. Regulation 17(1)(2)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients can access care and treatment in a timely way. Regulation 12(1)(2)(a)(b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients privacy and dignity is maintained at all times. Regulation 10(1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway. Regulation 17(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients, including those who present with mental health concerns, are managed in an environment which is fit for purpose. Regulation 12(1)(2)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Ensure the privacy and dignity of patients is protected at all times. Regulation 10(1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Ensure patients can access care and treatment in a timely way. Regulation 12(1)(2)(a)(b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Ensure patients, including those who present with mental health concerns, are managed in an environment which is fit for purpose. Regulation 12(1)(2)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway. Regulation 17(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children. Regulation 18(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care Section 29A Health and Social Care Act 2008