

Norfolk and Norwich University Hospitals NHS Foundation Trust

Norfolk and Norwich University Hospital

Inspection report

Colney Lane
Colney
Norwich
NR4 7UY
Tel: 01603286286
www.nnuh.nhs.uk

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Ratings

Overall rating for this service

Requires Improvement 

Are services safe?	Requires Improvement 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive to people's needs?	Requires Improvement 
Are services well-led?	Requires Improvement 

Our findings

Overall summary of services at Norfolk and Norwich University Hospital

Requires Improvement ● → ←

We carried out this unannounced focused inspection because we had concerns about the quality of services. The emergency department (ED) had continued poor performance in the trust's ability to meet national targets, which posed concerns about patients' safety. The service was rated as requires improvement at our last inspection in December 2019. As this was a focused inspection, we did not inspect all key questions. Our priority was to identify if the service was safe and well led.

We did not inspect any of the trust's other core services. This included surgery, outpatients and end of life care previously rated requires improvement, good and outstanding, respectively. This was because our inspection was part of the urgent and emergency care focused inspection programme. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

During our inspection we identified a breach of regulation 12, Safe Care and Treatment. We took action under our enforcement powers, by issuing the provider a Warning Notice served under Section 29A of the Health and Social Care Act 2008.

Our rating of services stayed the same. We rated them as requires improvement because:

Patient risk assessments were not always timely and there was not effective prioritisation and triage of patients. We saw seven patients triage delayed over one hour which included one patient waiting in physical discomfort with clear abdominal pain.

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves, and others from infection.

Equipment checks were not always recorded. There were omissions in the daily checks of emergency equipment and life critical equipment.

The service did not have enough nursing and medical staff with the right qualifications, skills, training, and experience. However, the trust took mitigating actions to address the staffing shortfalls.

People could not access the service when they needed it and did not receive the right care promptly. Waiting times and arrangements to admit, treat and discharge patients were not in line with national standards. Some patients waited for long periods to get care and treatment.

Triage and prioritisation of patients was not embedded. We identified several patients whose triage was delayed.

There were gaps in audit results in response to issues with IT connectivity. This resulted in gaps in information, reducing the ability to monitor performance.

Our findings

There was a stable leadership team in place however, we found that leaders had failed to adequately address risk to performance and sure this was effectively managed.

Leaders and teams used systems to manage risk, however performance issues remained that impacted on the quality and safety of care.

However;

The ED design was suitable and met national standards.

Most staff felt respected, supported, and valued. They were focused on the needs of patients receiving care.

Leaders operated governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

How we carried out the inspection.

We spoke with 28 staff across a range of disciplines including lead nurses, senior nurses, healthcare assistants, emergency department (ED) consultants, a trust grade doctor, a junior doctor, a matron, the hospital ambulance liaison officer (HALO), the divisional nurse director, and the divisional associate medical director. We attended two ED safety huddles and a patient flow meeting.

As part of the inspection, we observed care and treatment and looked at ten care records. We analysed information about the service which was provided by the trust.

You can find further information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>

Urgent and emergency services

Requires Improvement   

Our rating of this service stayed the same. We rated it as requires improvement.

Is the service safe?

Requires Improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

Mandatory training

The service provided mandatory training in key skills including the highest level of support to all staff and made sure everyone completed it.

The trust provided mandatory training to staff in several topics, including child and adult safeguarding, information governance and infection prevention and control. Training was largely completed through online courses, although some topics were completed in person. The ability to attend teaching sessions had been impacted by the COVID-19 outbreak, however compliance was maintained where possible.

Managers kept records of training completed and encouraged staff to complete training to maintain compliance.

Staff knew their roles and responsibilities in maintaining competence. For example, Staff told us they completed their safeguarding training both face to face and online and would escalate concerns to their managers.

Cleanliness, infection control and hygiene

The service did not always control infection risk well.

Staff did not always wash their hands between patients in the rapid assessment and treatment service (RATS) and triage. This meant staff were not always adhering to the trust's hand hygiene policy and procedure.

The trust used perfect ward audits to review their compliance in infection control audits completed in all ED areas. We reviewed the audit results from the infection prevention and control (IP&C) dashboard for RATS from June to November 2020. This showed that, hand hygiene data was only collected for three of these months, but the pass percentage never fell below 91%. This was above the trust target of 90%.

Staff did not always use equipment and control measures to protect patients, themselves, and others from infection. Staff did not always wear face shields when they were within a meter from patients, despite this being part of the recently revised Personal Protective Equipment (PPE) policy. For example, we saw a member of staff help a patient walk to the toilet without wearing a face shield. We saw five triage nursing staff were not wearing any eye protection when within two metres of patients, placing them at risk of COVID-19 or other viral/transmittable airborne diseases. We reviewed the trust's latest PPE procedure (version 1.8) from November 2020. Section 7.10 of the procedure stated goggles (eye protection) and face shields should be worn; *'to protect HCW's from contact with infectious material from patients, e.g. respiratory secretions and body fluids.*

Urgent and emergency services

The department's main waiting room area did not clearly highlight the need for people to socially distance using signs or furniture. Some of the 32 chairs had labels on advising patients not to use them, however, people were sat within a metre of each other. At the time of our inspection ED's waiting area had been extended along a corridor with single chairs placed two metres apart. However, nearly all patients were sat in the main waiting room and were not incentivized to move into the safer corridor environment.

We were told that patients were reminded to wear masks unless exempt. All patients were offered a mask if were not wearing one upon arrival. ED reception staff told us if people were uncooperative with social distancing, they would inform the nurse or contact security if needed. When the waiting room became full, escalation occurs with a response from specialties.

ED leads knew where and how many patients were confirmed to have COVID-19 in their department at all times. At the time of our inspection, the trust had been on level four alert for local COVID-19 prevalence for the past three weekends. The covid alert level is a five point alert system with changes in alert level made on recommendation by the chief medical officers and NHS England.

All patient-facing staff were tested for COVID-19 twice weekly. If these staff had any symptoms, they would inform their manager and stay at home.

We saw ED nursing staff treating one patient with MRSA confirmed in their medical notes in an open bay of the majors ward. MRSA is a type of bacteria resistant to several widely used antibiotics. Staff were not wearing gloves or aprons. This meant there was a potential risk of cross-contamination from this patient to other patients and staff not wearing the correct personal protective equipment (PPE). We reviewed the trust's latest PPE procedure (version 1.8) from November 2020. Section 7.8 of the procedure stated gloves should be worn when; *'There is a risk or potential risk of contamination by direct contact with blood or body fluids, mucous membranes, non-intact skin and other potentially infectious materials.'* Section 7.9 stated aprons/gowns should be worn; *'To protect the patient from infection and the wearers clothing/uniform when there is a potential risk of contamination with blood or body fluids or suspected infection risk.'* We reviewed trust wide indicator data on Insight. This showed the trust had no apportioned MRSA bacteraemia alerts since October 2019 up to the date of our inspection.

Within the rapid assessment and treatment service (RATS) we saw that the sharps box was soiled with dried blood, this was escalated to staff and cleaned.

Staff kept equipment and the premises visibly clean. We saw trolleys and trolley spaces being cleaned between patients. Triage nursing staff wiped down chairs and blood pressure cuff between patients and washed their hands.

Environment and equipment

The design, maintenance and use of facilities, premises kept people safe. The ED design was suitable and met national standards.

There were two triage rooms accessed from the main waiting area. The department had one resuscitation area with six bays, two of which were separated by sliding screen doors for aerosol generating procedures (AGPs). The rapid assessment and treatment service (RATS) area was suitable for patient needs. The open environment allowed staff to easily observe all cubicles which had visible monitors and computers for completing documentation. This area had 15 cubicles and one side room. The department had utilised space by installing two pods staffed by ED nurses and doctors in the entrance corridor for ambulatory patients.

Urgent and emergency services

There were mental health (MH) quiet rooms where patients could be reviewed by the MH liaison team based in ED full time. We observed these rooms which were ligature free, had panic alarms and a second internal door staff could access. ED staff had developed a police handover form to give them a clearer timeline of MH patient journey. However, the physical ED layout was not always conducive to optimise patient flow. Different areas and patient pathways within the department were dispersed.

Resuscitation equipment was accessible to all clinical areas; however, equipment checks were not always completed. In the rapid assessment and treatment area (RATS), the resuscitation trolley had 14 omissions in checks between 12 October up to the date of our inspection. There were also gaps in resuscitation trolley daily checks within the older people's emergency department (OPED) where we found five omissions since late October 2020, with blank columns, no signatures, or dates.

We also found the OPED and majors ward's hypoglycaemia boxes had several checks omitted. We requested details of equipment checks following our inspection which showed that there were gaps in weekly box contents checklists. For example, the week commencing the 6 December, we saw gaps on Thursday 10, Friday 11 and Sunday 13 December 2020 were also incomplete or blank. The checklist stated staff should check all contents daily. Staff had only signed their name and pin code below for 10 December so if items were unsealed, missing, or expired on the other dates their replacement would be delayed. We told the deputy sister who explained this was normally done by the night shift but could not explain why there were gaps.

There were also gaps in checks of the hypoglycaemic box in the children's emergency department (ChED) for the same week, with omissions on Sunday 6 and Wednesday 9 December 2020.

However, the trust informed us gaps atop the checklist showed staff did not complete the date and time, rather than failing to undertake the check altogether. Staff had signed their names and pin codes below so they could be contacted if items were unsealed, missing, or had expired. Staff checked the box daily and confirmed it was sealed by documenting the seal reference number.

Staff told us that equipment was readily available to support their planned treatment. For example, staff could access infusion pumps, monitors, and medicines.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. However, assessments were not timely and there was no prioritisation of patients.

Patients arriving in the department were initially seen by a streaming nurse who then directed patients to the most appropriate clinical pathway based on a brief presenting history. The streaming nurse did not record COVID-19 screening tool criteria on the UEC clinical system or measure and record basic observations. Patients were not registered into the department at this point. This approach was in line with the royal college of emergency medicine's (RCEM) recommendations, which state the process of directing patients before a formal clinical assessment is most safely undertaken by a clinician.

There were two pathways for patients attending the department depending on whether they were potentially COVID-19 positive or not. Streaming facilitated patients into the designated red or amber pathway areas safely. Patients who answered yes to any of the potential COVID-19 questions, were referred to the red pathway. All other patients sat in ED's main waiting room and were booked in for triage.

Urgent and emergency services

During inspection, we did not see evidence of triage prioritisation and there was no clear system to pull patients from the triage queue if they deteriorated. Patients were not always seen within 15 minutes of arrival to the department. We saw seven patients triage delayed over one hour which included one patient waiting in physical discomfort with clear abdominal pain.

We reviewed the total number of ambulance transports into ED during December 2020. Of 4,213 journeys, 2,163 of these patients were handed over within 15 minutes. This was 53.7% of the total handovers recorded in December 2020 (187 had no handover time recorded). This meant just under half of December's total ambulance transports did not meet the trust target. We reviewed the total percentage of ambulance transports into ED from December 2019 to December 2020. This percentage had improved from 24.4% in December 2019 to 66.3% in November 2020 for handovers within 15 minutes. However, the percentage had fallen from 56.3% in September 2020 to 51.3% in December 2020.

Patients were not always seen in a timely manner. On the date of our inspection, 8 December 2020, data showed ED had one 12-hour breach, and 104 four-hour breaches. The department's 12-hour breach was due to a lack of available mental health beds at other providers. This patient was transferred on the date of our inspection.

Staff used national tools for assessing risks and were trained in managing emergencies appropriately. ED staff recorded patient observations using the national early warning score (NEWS2). NEWS is a simple, physiological score that may allow improvement in the quality and safety of management provided to patients. The primary purpose is to prevent delay in intervention or transfer of critically ill patients. NEWS scores were displayed on the trust's 'UEC clinical system' so staff could observe patients at risk of deterioration.

We saw three patients on trolleys waiting for a bed on an inpatient ward. There was little evidence to suggest all risk assessments were completed. For example, we found staff did not always record evidence of pressure area care in patient notes. This meant patients were potentially at risk of tissue and skin damage as a result of no pressure area assessments or prevention. We also saw that patients' clinical observations were not always completed. Staff recorded several sets of observations in patients notes, however, four out of five sets of notes requested hourly observations which were not completed.

Staff were clear of their roles and responsibilities and worked collaboratively with other staff. Patients at risk of deterioration, or those needing urgent care or treatment could be flagged to ED staff by ambulance crews, facilitating an assessment onboard the ambulance. The department had a rapid assessment and treatment service (RATS) standard operating procedure (SOP) and a clinical support and safety nurse with clearly outlined competencies for this role. Information was clearly relayed to a nurse at the handover station and information was typed directly into the trust's electronic notes system and the patient allocated a cubicle. If ambulances were unable to offload patients, the patients were assessed onboard the ambulance by ED staff or the band 7 safety nurse. This safety nurse was allocated daily and their role was to complete the ED safety checklist for all patients assessed on emergency vehicles, provide an extra point of contact for advice and guidance, and escalate patients who required immediate attention to the resuscitation coordinator and lead nurse to prioritise patient transfer to appropriate ED areas.

We reviewed ED's minutes from arrival by ambulance to initial assessment for the week of our inspection (1 to 8 December 2020). The department's only 60 minute breaches were on Monday 7 December, when they had 13 breaches. This was 8.9% of their total number of conveyances that day. Of their 146 conveyances, 38 had no handover recorded.

There were processes in place to assess the risk of sepsis. The department used national guidance and trained staff in recognising and treating sepsis, although we did not see this in use during our inspection.

Urgent and emergency services

Department leads, the operations manager and site team staff attended ED safety huddles every three hours. The main huddle room had an ED dashboard of performance against national targets onscreen, as well as inbound ambulances and an urgent and emergency care (UEC) clinical system which supported patient management, tracking and clinical workflow.

Receptionists had a list of “red flag” conditions to refer to where they would inform the triage nurse urgently. If a patient said they wanted to leave, receptionists encouraged them to stay until they were seen by a triage nurse if needed.

ED had a response plan for COVID-19. The department had been segregated into different colour pathways where the layout was adapted to be COVID-19 secure for patients and staff in green areas. Children went directly to the Coltishall paediatric ward to avoid ED areas. Adults and children confirmed not to have COVID-19 could stay in the ED’s yellow pathway areas. The minor injuries area did not admit patients with any COVID-19 symptoms.

The trust used the NHS England and Improvement approved Rainbird workplace risk assessment tool for COVID-19. The tool includes a detailed occupational risk assessment based on the individual's medical history, underlying health conditions, and social factors contributing to their COVID-19 risk factors. All ED staff were required to complete this risk assessment. Staff identified as moderate risk or above undertook a manager-led risk assessment. The assessment identified the department areas the staff member could work in and any mitigating factors that can be put in place. This information was held on a spreadsheet and shared with the ED team for the appropriate allocation. However, the assessments made it hard for the matron and other staff schedulers to allocate staff to different areas of the department. A lead nurse told us Rainbird did not consider staff member’s full past medical history.

Emergency call bells were located in each clinical area and the main waiting area. The minor injuries waiting area had been recently refurbished and patients had emergency call bell access. ED was spread over a large area. Consultants we spoke to described how difficult it was to manage the department layout as visibility was lacking. They explained this could become a challenge, especially when the department is busy.

Nurse staffing

The service did not have enough staff with the right qualifications, skills, training, and experience.

We reviewed ED staffing on the day of inspection and found the department’s early and night shifts had 23 qualified nursing staff and 17 HCAs. There were an additional two staff allocated a twilight shift. These numbers did not include emergency nurse practitioners (ENPs). The department’s number of registered nurses on the early shift was five less than planned and four less than scheduled on the late shift. Nursing leads told us they were often four or five qualified nursing staff short on each shift. ED leads were flexing nurse staffing across several areas.

ED leads highlighted these shortfalls as ‘red flags’ on the trust’s electronic staffing management system. Shortfalls were discussed and mitigated at safer staffing meetings. On the date of our inspection ED’s staffing gaps were mitigated using three ED clinical educators to provide clinical support. The department also had five supernumerary staff on long days. These staff comprised of two registered nurses, a nursing associate and two HCAs.

At the time of our inspection, OPED staff told us there were reduced numbers due to staff self-isolating in response to COVID-19. As a result, OPED covered shifts using bank and agency nurses who were familiar with the ward where possible.

Urgent and emergency services

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency, and locum staff a full induction. Nursing leads told us the ED had increased nursing numbers by two staff per shift, in response to COVID-19. ED leads adjusted their nursing staff numbers to respond to patient's higher acuity. For example, COVID-19 state 3 response shift allocations were increased when the department saw over 25% of attendances through the red pathway for over three consecutive days.

Staff were allocated to roles based on their COVID-19 risk assessment outcomes. For example, staff with underlying health conditions were shielding or transferred temporarily to areas with less associated risk. On inspection a senior ED staff member told us their department was currently working with a 6% extra loss of nursing staff due to COVID-19 related factors. This was in addition to their normal nursing staff absence rate. Post inspection the trust sent us the department's total absence rate for the week ending 6 December on the trust's Power BI dashboard. This was 8.5% overall, with 4% attributed to COVID-related absence and 4.5% other sickness.

On inspection one lead nurse explained nurse staffing gaps meant ED could not always have an allocated safety nurse. Post inspection the trust provided evidence the department had a clinical support and safety nurse (CSSN) allocated on every shift. The ED lead nurse used discretion to deploy this CSSN to optimise the department's safety, efficiency, and effectiveness.

On inspection a lead nurse told us their nurse staffing was spread thinly. The ED nursing establishment and budget has increased as the department's footprint has grown. However, post inspection trust data provided did not confirm which months these uplifts were introduced or proposed. The uplift for band 6 and 7 nurses was in month 5 but we could not be sure which months this data referred to. The ED lead nurses held twice-weekly 'look ahead' meetings where nurse staffing was scrutinised 11 days in advance. This also allowed vacant shifts to be offered to bank and agency and filled proactively. Any staffing shortfalls were highlighted as 'red flags' on the trust's electronic staffing management system. These were discussed and mitigated at the twice daily 'safer staffing' meetings.

Competencies

A trust health roster had a skills monitor to ensure the right staff mix were allocated to each shift. The trust adopted a multidisciplinary approach to advanced life support (ALS). ED had skilled ALS trained nursing and medical staff available at all times. There is no minimum national *requirement for nursing staff on shift to be trained in ALS*. At the time of our inspection the trust was implementing guidance from the nursing workforce standards published in October 2020 for type 1 EDs. These standards state charge nurses should be competent at level 2 of the national curriculum and competency framework for emergency nursing, including ALS.

Newly qualified and new to speciality nursing staff were supported to gain ED specific skills and competencies. These staff received a new starter pack and undertook an eight-week induction. They were also enrolled in the department's two-year foundation programme, based on the royal college of nursing (RCN) and emergency care association national curriculum and competency framework for emergency nursing. Staff on this programme have bimonthly study days based around the theory within the emergency nursing competency framework. Leads had oversight of staff competencies as they were recorded on a tracker to review any gaps. ED also had a healthcare assistant (HCA) competency pack.

Urgent and emergency services

ED had 15 annual spaces for nursing staff to complete their advanced life support (ALS) training. ED had 27 nursing staff trained in ALS, with 15 more due to be completed in February 2021. This was low in terms of their total numbers of staff working in the department. ED had increased the number of places from four in 2018 to 15 places annually since 2019. At the time of our inspection ED was supporting 15 registered nurses to complete the course. The department planned to request funding for an additional 42 ALS places in the next financial year.

A clinical educator told us the department was looking to roll out immediate life support (ILS) to all staff from January 2021. The practice development nurse was liaising with the trust resuscitation lead to provide ILS to all registered nursing staff in 2021.

Children requiring treatment were sent straight to the children's emergency department (ChED). ChED was staffed separately from ED. Trust data confirmed 73% (13) of ChED's registered children's nurses (RCNs) had an active European Paediatric Life Support (EPALS) qualification. The ChED RCNs with EPALS always staffed ED's paediatric resuscitation bay. RCNs from ChED accompanied any child moved to resuscitation. If a paediatric arrest call was made anywhere in ED, the paediatric arrest team included an EPALS trained staff member who attended from paediatrics. Every shift in paediatrics was covered with a minimum of one EPALS member who carried the arrest bleep. The department had a trajectory to have 100% of ChED RCNs qualified in EPALS by September 2021.

The division had escalated the lack of training on the European paediatric advanced life support (EPALS) course due to social distancing and cancellation to the children's board. We reviewed divisional clinical governance meeting minutes for September 2020. The division had 80 trained staff members of the adult cohort with paediatric competencies. ED's shift establishment was three paediatric nurses and one adult nurse on shift. The division was in the process of negotiating two combined clinical assessment unit (CAU) consultants who will be paediatric trained to support work within the main emergency department.

Children's ED (ChED) was separate from the main department and only took non-COVID-19 child patients. ED provided one adult registered nurse (RN) to ChED with paediatric competencies who worked alongside registered children's nurses (RCNs) to provide 24 hour cover. The paediatric nurse staffing met the royal college of paediatric and child health's (RCPCH) national guidance as per *recommendation 10: EDs treating children must be staffed by two registered children's nurses*. Trust data from 16 December 2019 to 13 December 2020 showed paediatric nurse staffing met RCPCH national guidance for 99.5% of shifts. ED rosters showed at least two RCNs were on duty in ChED for a total of 732 shifts. ED leads rostered all shifts in ChED to provide three RCNs during the day (7am-7.30pm), one RCN on a twilight shift (11am-11.30pm) and four RCNs at night (7pm-7.30am). The trust only fell partially short of the requirement to provide two RCNs for 0.5% of shifts in ChED over the 12 months. These were four 12-hour night shifts where this was mitigated by adult registered nurses (RNs) with paediatric competencies from ED.

We spoke to a department educator undertaking a skills gap analysis against the RCN's emergency nurse competencies. The department planned to use the analysis results to improve nursing staff skills and workforce resilience.

Staff told us that agency and bank staff were being offered supervisory days where they worked alongside a nurse and were given an induction pack to ensure competency.

Medical staffing

The service did not have had enough medical staff with the right qualifications, skills, training, and experience.

The service provided 24-hour medical cover using substantive and locum doctors.

Urgent and emergency services

Consultants told us the skills mix was a challenge as multiple junior medical staff were locums. On the date of our inspection, medical staffing were two doctors short for the twilight shift and three less than planned for the morning shift.

Medical staff told us there were “extreme staff shortages” which put a lot of pressure on the other staff, especially the emergency physician in charge (EPIC). Department leads were carrying out recruitment and retention work and planned to recruit 13 medical staff posts such as junior and senior clinical fellows in response to their doctor’s rota gaps due to vacancies.

On the day of our inspection the minor injuries area had no doctor for the morning shift but a consultant was allocated to minors from 1pm to 9pm. ED’s minors service was emergency nurse practitioner (ENP) led. Patient numbers attending ‘minors’ was low in the mornings, and leads allocated doctors to minors from lunchtime onwards. The emergency physician in charge (EPIC) looks at the allocation of doctors daily at the 8am handover. They allocated doctors to the areas they were needed. If the minors area was busy in the morning the EPIC sent a doctor there to help. The department based two consultants mostly in minors as they returned to work from shielding and could not work in the main ED. This meant minors had consultant presence most days, including weekends.

ED leads had increased medical staffing enhancements for all evening and night shifts from October 2020. It took them a few weeks to fill shifts with regular locums and build up relationships with junior doctors. Leads filled the empty shifts and already increased doctor numbers on the night shifts from eight to ten doctors on the 10pm-8am shift in response to more patients during the second COVID-19 wave. Leads held discussions and made plans at safety huddle meetings about staffing and mitigations in a dynamic manner according to patient demand. If the department needed extra medical staff support, the EPIC asked ED consultants on their supporting professional activity (SPA) to help on the floor.

We reviewed an ED performance summary for October 2020. This showed the department’s medical staffing was worst affected on nights, Sunday, and Mondays. Medical staff shortages meant that patients care, and safety was at risk. Staff said that shortages resulted in high numbers of patients needing to be seen in the mornings placing additional pressure on oncoming staff members and delaying discharges.

Same day emergency care (SDEC) pathways were in their early stages for ambulatory walk-in patients. SDEC provision for emergency patients reduced the number of patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed, and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided. On inspection an ED consultant told us medical staff shortages in medicine and surgery impacted on the department’s ability to set up more patient pathways to specific areas from the front door. However, post inspection the trust provided data that showed chiefs of division for medicine and surgery have confirmed there were no shortages in staffing in their divisions that delayed pathway development. The chief of division for surgery led an improvement workstream that looked explicitly at pathway development to assessment areas between July and November 2020.

Emergency and urgent care divisional leads had reduced or cancelled role specific medical training and teaching to increase staff availability. This was in response to their assessment and treatment delays due to medical staffing shortages. As a result a lead consultant was appointed to oversee training and teaching. The lead ensured any cancellations were identified and an incident report raised for an audit trail. Medical training had resumed six weeks before our inspection. The department has had no teaching cancelled since 22 October 2020. All ED consultants had also been job planned to ensure teaching was included.

Urgent and emergency services

We reviewed the latest emergency and urgent care (EUC) risk register. The division's medical staff had a vacancy rate/shortfall of 6.1 consultants, 12.5 registrars, plus 30 other posts including, senior house officers (SHO), emergency nurse practitioners (ENP), advanced care practitioners (ACP) and GP's. However, the trust had controls in place and ongoing measures to address this shortfall. For example, the use of locum staff. ED locum rates had significantly improved with incentives for clinicians. In view of these improvements, leads had reduced this risk on the risk register, but they continued to monitor closely and review monthly.

Children's ED (ChED) could not always meet the royal college of paediatric and child health's national guidance to provide a paediatric emergency medicine (PEM) consultant as per recommendation 9: EDs treating children must be staffed with a PEM consultant with dedicated session time allocated to paediatrics. Leads reviewed ChED's medical staffing twice weekly as part of their weekly staffing review.

Medical staff told us they had regular teaching sessions for junior doctors and the induction was well set out. We were told all the consultants had their job plans reviewed and there was protected time for recruitment and retention.

Is the service responsive?

Requires Improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

Meeting individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The main ED waiting area met the royal college of emergency medicine's (RCEM) best practice guideline on ED care from July 2017. The patient environment was furnished with Wi-Fi access, information regarding process, updated waiting times and wipe-clean reading materials. However, the waiting area did not provide patients with safe social distancing. Chairs were not spaced further than one metre apart and patients did not maintain safe social distancing. Staff told us they reminded patients to maintain safe distances where possible.

Main clinical areas and corridors were segregated from public areas by restricted access doors with swipe card or receptionist approval. The children's emergency department and the older people's emergency departments had restricted access to ensure patient safety. Children attending the emergency department for treatment were always accompanied by a responsible adult.

The service provided care for frail/elderly patients in the older people's emergency department (OPED). This consisted of two side rooms and a four-bedded bay totaling six beds. Main ED trolleys comprised the rest of the space in three six-bedded bays and three side rooms (21 beds). OPED was open from 8am to 5.30pm daily. Staff transferred day patients onto COVID-19 safe wards after this time. Emergency medicine staff looked after this area once the older peoples medicine team finished at 5.30pm.

Urgent and emergency services

We saw that staff provided families with clear explanations of the risks of COVID-19 for children. Information had been simplified to ensure that children could understand why there were some rules in place for their visits, such as no mixing with other children.

Patients who used walking aids or wheelchairs were able to access all areas of the emergency department and there were disabled toilets available.

Access and flow

People could not access the service when they needed it and did not receive the right care promptly.

Patients attending the emergency department (ED) waited to be seen by a triage nurse and by a doctor which impacted on the service's overall performance of the triage time and national targets. Patients waited for long periods to access the care they needed. We saw there were 81 patients in the department when we arrived for inspection at 1pm. Data showed that there had been 104 four-hour breaches including one 12-hour breach for the 8 December 2020. This meant 104 patients had not been seen in a timely way.

A qualified streaming nurse saw all ED walk-in patients at the front door. The streaming nurse directed patients to the most appropriate clinical pathway/service based on a brief presenting history. They also assessed patients for COVID-19 symptoms before awaiting initial assessment. Patients who were COVID-19 symptomatic were streamed into a different pathway whilst those with no symptoms were asked to wait in the main waiting room for triage.

Waiting times, from arrival to the department to triage were varied. We saw seven patients were waiting for over one hour to be seen by a triage nurse following arrival in the department. At least three of these patients were admitted with some form of pain. For example, one patient, admitted with abdominal pain arrived at 12:06 and was not triaged until 13:29.

We reviewed the total number of ambulance transports into ED during December 2020. Of 4,213 journeys, 2,163 of these patients were handed over within 15 minutes. This was 53.7% of the total handovers recorded in December 2020 (187 had no handover time recorded). This meant just under half of December's total ambulance transports did not meet the trust target. We reviewed the total percentage of ambulance transports into ED from December 2019 to December 2020. This percentage had improved from 24.4% in December 2019 to 66.3% in November 2020 for handovers within 15 minutes. However, the percentage had fallen from 56.3% in September 2020 to 51.3% in December 2020. Leads told us they had been working on improving ambulance turnaround performance.

Once triaged, patients waited to be seen by a doctor. The trust target from the time of patient's arrival to be seen by a doctor or clinical professional was 60 minutes. We reviewed the median time from patients arriving in ED to being seen by a doctor. From 1 June to 1 November 2020, this time averaged 90 minutes. The trust target had not been achieved in the six months preceding the inspection. Although data showed that there had been a slight improvement from August 2020, when the median waiting time for patients had fallen from nearly 100 minutes to 65 minutes by November 2020.

We reviewed NHS Digital's urgent and emergency care indicators on ED quality. The trust's total median time in ED (from arrival to departure) for all patients had increased slightly from 3.6 hours in October 2019 to 3.7 hours in October 2020. This was above the England average of 2.6 hours. The trust's number of ED attendees who spent more than 12 hours from their decision to admit (DTA) to admission had also risen from six in November 2019 to ten in November 2020, rising again to 12 in December 2020.

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Data showed that ED's median time from arrival to departure for all patients from 1 December 2019 to 1 November 2020, met the trust target of four hours for the whole period. The median time had reduced from over 230 minutes on 1 December 2019 to around 211 minutes, by 1 November 2020. The month with the lowest median time was 1 April 2020 with 192 minutes.

Although there had been some improvements with the emergency departments performance, data shows that they were worse than the England average for meeting the four hour target for patients attending majors, and any type of ED.

The percentage of patients who spent less than four hours in ED had improved from 55.3% in November 2019, to 60.2% in November 2020 though this was worse than the England average of 76.8%. The percentage of patients who spent less than four hours in (any type of) ED had improved from 59.1% in November 2019 to 73.8% in November 2020. Below the England average of 82.1%. When we left ED at 8pm on the 8 December 2020, NHS England's four-hour target was met for 50.5% of patient admissions. This meant nearly half of the patients attending the department were not seen in line with targets and waited over four hours.

During inspection, we saw there were no ambulance handover delays. We reviewed ambulance turnaround performance for the week of our inspection (ending 13 December 2020). We saw that, the trust had 137 handover delays, which was the number of arrivals to handover hours lost over 15 minutes. This was equivalent to 11 whole, 12-hour ambulance shifts lost for the week. This figure is roughly average for the East of England (EoE) region. Annual ambulance turnaround performance data for the trust showed a loss of 3419 hours in 2020/21 year to date due to delays in handover. This was an improvement from the 2019/20 data when 6935 hours were lost.

We reviewed the trust's performance for 15, 30 and 60 minute ambulance handovers, for the six months before our inspection. In the four weeks from 9 September to 8 October 2020 the trust reported 2,530 ambulances achieved a handover within 15 minutes (61% of the total recorded handovers) and 1,139 handovers within 30 minutes (28% of the total recorded handovers). For the same period, 81 ambulances were unable to handover within 60 minutes. This was 2% of their total recorded handovers.

The trust recorded a breach as any handover over 60 minutes. Data showed a consistent improvement from 18.17% to 1.25% over the 13 month period preceding the inspection.

ED staff liaised with a hospital ambulance liaison officer (HALO) onsite. This allowed for faster ambulance turnaround times. If staff could not immediately offload patients upon arrival, staff would assess them to understand their clinical severity and priority.

Although we did not see any harm as a result of delays in treatment, there were potential risk to patients from spending too long in ED. For example, we saw that one patient had been in the department for ten hours and 51 minutes, and was waiting for transport home, they remained on a hospital trolley a cannula in their arm. Upon reviewing the patients notes we found very little evidence of pressure area care. Data shows there was a worsening trend in percentage of patients waiting over four hours from decision to admit to admission. This was 36% in October 2020 rising to 45% in December 2020 which was persistently higher than the England average.

We reviewed ED's median time from decision to admit (DTA) to admission for all patients from 1 December 2019 to 1 November 2020. This had never met the trust target of 30 minutes. The closest month ED came to meeting the target was

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July 2020 with an average of just under 100 minutes. The highest monthly median time was February 2020 with an average of over 300 minutes. We were told by nursing staff that there were lengthy delays for patients waiting an inpatient admission, due to limited bed flow trust wide as a result of limited daily discharges. We saw three patients waiting for an inpatient bed.

Hospital flow was managed by the site team and we observed a site operations meeting chaired by a daily assigned site manager. This reviewed regional hospital sites and ambulance services to manage and anticipate capacity across the system. Current ED positions and discharges were discussed. At the time of our inspection this meeting was held every two hours as the hospital was in OPEL status 3.

Patients discharged from the department were given advice on the next steps, for example if they needed to attend their GP or return to hospital.

Is the service well-led?

Inspected but not rated ●

There was a stable leadership team in place however, we found leaders had failed to adequately address risk to performance and ensure this was effectively managed.

Leaders were not always aware of risks and issues as identified issues with PPE and handwashing within the department. We identified risks in infection control that were not being managed appropriately within the department. There had been a failure to make a demonstrable impact on issues of performance within the department.

Whilst leaders understood the priorities and issues the service faced there had continued to be issues within the service impacting on patient care. In response to assessment and treatment delays due to medical staffing shortages, the divisional associate medical director (AMD) along with the service director, ED operations manager and workforce coordinator processed plans for the roster and real time gap analysis. The assistant medical director and rota coordinator held a twice-weekly look ahead. They reviewed the rota and looked two to three weeks ahead to identify and address any rota gaps concerns. The rota coordinator emailed and sent individual messages through a social networking app to regular locum staff where there are upcoming gaps. They also send out the available shifts six weeks in advance so locums can book into them in good time.

Urgent and emergency services were led at a senior level by a chief nurse, medical director, and chief operating officer. Operationally the service was led by a divisional nursing director, operations director, and associate medical director (AMD). Day-to-day oversight of the department was managed by the senior matron, service director and operations manager. Nursing and medical leads we spoke to had the relevant competencies for their roles.

Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Staff we asked spoke highly of the matron, nurse director and service director. They felt ED leads were visible and supportive when they raised any concerns. Leaders provided clear escalation plans and processes and ensured that staff understood and followed them, supporting staff with changes.

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Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care.

On past inspections we had found long standing issues with the department's culture. However, during this inspection we saw there had been some improvement. Staff reported working cohesively to ensure effective care and treatment. Consultants told us they were working with specialty consultants to redesign patient pathways to improve patient flow through the hospital.

A number of staff told us that they felt pressured due to the shortage of staff at times as well as pressures to staff more clinical areas within the current ED footprint. This impacted on staff morale and potentially patient safety. Other staff were largely positive about their roles and responsibilities and the positive mental health and morale of department staff came across well.

ED staff frequently liaised with specialties across the hospital for clinical advice. Consultants told us they worked better together as a cohesive group and had done lots of work on improving flow. For example, one ED consultant had worked on internal professional standards (IPS) to provide more support in the department from cardiology and other specialties during COVID19. We read these IPS' were agreed at the trust's hospital management board (HMB) and communicated trust wide as part of changes after an ED escalation project.

Governance

Leaders operated governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a robust audit calendar which was reviewed by local, division and senior leadership teams. However, audit results could not always be fully recorded. Trust and divisional leads told us there had been several issues with perfect ward audits since November 2020. There were connectivity issues and results were recorded as 0% even when an audit had been completed. These issues had been escalated and had been fixed but had resulted in a drop in audit compliance as staff lost faith in the system working. Leads were addressing this by having a dedicated infection prevention and control (IP&C) lead nurse who with the IP&C link nurses were re-establishing these audits.

ED audits were shared at monthly clinical governance meetings. We reviewed the divisional clinical governance meeting minutes from September 2020 which showed details of an ambulance handover audit and the actions taken in response to findings. We saw that findings were circulated to all staff. We saw lessons learnt from root cause analyses had not always been actioned. We reviewed the trust's root cause analyses (RCAs) for ambulance offload delays over an hour to adult and children's ED (ChED) in June, July and September 2020. Some examples of the department's care and service delivery problems were long waits to be seen within ED, a lack of flow throughout the trust and IT failure. This meant staff struggled to ascertain how long ambulances were outside and/or record accurate handovers. Root causes and lessons learnt were given with actions on how the trust planned to improve. However, at the time of our inspection, two of the lessons learnt had not been actioned. One was creating early trust wide flow to cope with anticipated high volume of patients in the early evening. The other was ensuring correct number of ED medical practitioners were available. An emergency and urgent care (EUC) action evidence group reviewed actions from all SI reports on a weekly basis. Actions were supported with evidence to give assurance.

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The department had established pathways for patients who attended the department with conditions such as mental health. Advice was available for patients to support their treatments and staff were able to refer to specialist practitioners or direct them to relevant services, as necessary.

There was a process for ensuring all documentation was aligned to the most recent guidance. Any ED documents that were nearing their review dates, such as standard operating procedures (SOPs) and the National Institute for Health and Care Excellence (NICE) guidelines were highlighted in the division's clinical governance meeting minutes with assigned leads to update at the next meeting.

The division had a "gossip from governance" bi-weekly newsletter to update staff on relevant information. These included a 'Greatix award' each month to celebrate staff achievements. For example, October 2020's award went to a staff member who wrote incident reports in a serious incident format which really helped investigations.

Management of risk, issues and performance

Leaders and teams used systems to manage risk however performance issues remained that impacted on the quality and safety of care.

We identified ongoing concerns with the performance of the department that we have reported on at previous inspections. Divisional and ED leads had taken action in response to their department's performance such as undertaking a workforce review. Whilst there had been a focus on improving performance including with additional support from the system, patients waited too long to receive the care they needed. Staffing issues both in terms of being short staffed within the emergency department as well as the impact of COVID-19 on staffing levels impacted timely decision making. We also identified risks within the department such as the incorrect use of PPE and hand washing.

Leaders identified and escalated relevant risks or issues and identified actions to reduce their impact though these were not always effective, such as, in the long delays that some patients waited for care. Trust, divisional and ED leads were very aware of the department's challenges. For example, the need to recruit substantive staff and the trust's large rural geographic area impacting discharges and the need to provide adequate patient transport.

The division maintained a divisional risk register which was reviewed at governance meetings. We reviewed the urgent and emergency care division's latest risk register and found that risks were scored using a recognised risk tool, with three risks scored 10 or above out of a possible 25. This included, long waits to be seen in the ED, delays in assessment/treatment due to medical staffing shortage and oversight of patients at high risk of deterioration were recorded. There were controls in place to mitigate these risks where possible. For example, the division had reduced or cancelled medical training to increase staff availability and provide clinical cover. All ED areas had COVID-19 risk assessments completed. These were reviewed and updated anytime an area's environment was changed. When the department became very busy, staff worked out capacity limits by area.

At the time of our inspection the trust was not using our Patient First document to improve ED performance relating to winter planning and pressure resilience. Patient first is a tool designed to support flow through emergency departments and reduce risks of overcrowding and nosocomial (hospital acquired) infections.

Department leads and department coordinators attended site team meetings daily to ensure that there was oversight of activity within the department and the potential impact of patients awaiting an inpatient bed. Leads were aware the department's delays in being able to promptly see patients was multifactorial. This was mainly due to exit block but also staffing shortages.

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Outstanding practice

We found the following outstanding practice:

The service provided care for frail/elderly patients in the older people's emergency department (OPED). This meant that older patients did not have to attend the main emergency department which could be busy and confusing for frail elderly patients.

ED had a band 7 safety nurse with clearly outlined competencies for this role. If ambulances were unable to offload patients, they pre-booked an assessment onboard with ED staff or the safety nurse. This safety nurse was allocated daily and would cover all areas of the department to maintain safety.

Areas for improvement

MUSTS

We took enforcement action to issue a section 29A Warning Notice because the quality of healthcare required significant improvement. In summary the reasons we issued this notice were:

- The trust must ensure ED staff embed an effective form of triage prioritisation to better respond to patients at greater risk of deterioration. Regulation 12 (2)(a)
- The trust must ensure they continue to do all that is reasonably practical to mitigate the risks of failing to meet key national and trust performance targets such as the four-hour standard, triage within an hour of patient's arrival and monthly decision to admit (DTA) patient numbers. Regulation 12 (2)(a)
- The trust must ensure ED nursing staff pressures do not cause delays in triage and the allocated safety nurse can fulfil their role properly. Regulation 18 (1)

SHOULD

- The trust must also ensure less of their junior medical staff are locums, and medical staff shortages do not limit their ability to set up SDEC pathways. Regulation 18 (1)
- The trust should ensure all ED staff adhere to the latest PPE guidance for COVID-19 and hand hygiene policy when treating patients. Regulation 12
- The trust should ensure all ED areas offer patients a suitable environment with clear signposting to help them socially distance. Regulation 12
- The trust should ensure ED staff in all areas complete daily checklists on all emergency equipment and medicine boxes. Regulation 17
- The trust should ensure that patients waiting areas are organised in a manner to prevent cross contamination or risk in line with social distancing. Regulation 15
- The trust should ensure that there are sufficient numbers of consultants within the Children's ED (ChED) in line with guidance. Regulation 18

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and two specialist advisors with experience within emergency care. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

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 18 HSCA (RA) Regulations 2014 Staffing

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment