

Leicester Royal Infirmary

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at the Leicester Royal Infirmary on 27 January 2020, as part of our winter pressure resilience programme. The decision to inspect was based on intelligence we held about the department and was associated to a potential increase in risk in patient harm.

At the time of our inspection the department was under adverse pressure.

We did not inspect any other core services or wards at this hospital. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry. We found that:

- There were delays in ambulance handovers and resultant delays in assessment and treatment for some patients.
- Whilst the service mostly had suitable premises, there were insufficient cubicles to accommodate all the patients in the department when it was overcrowded. As a result, patients were being cared for in a corridor at the time of the inspection.
- Triage times were not completed in line with guidance. Some patients waited a considerable time to be assessed.
- Whilst risks to patients were assessed and their safety monitored and managed, not all patients received treatment in a timely manner.
- Some doctors told us they needed more emergency department consultants to keep the department safe when it was overcrowded.
- Patients could not always access the service when they needed to due to the volume of patients arriving in the department. Some patients access to emergency care and treatment was significantly delayed.
- Specialty doctors were unable to respond to all patients in a timely manner.
- There was insufficient patient flow across the trust to admit all of the patients who required a hospital admission.
- Some senior medical staff told us the POD facility had been implemented without full and proper consultation or input from the emergency department team, and the extra ambulance capacity had increased the workload on an already over stretched department.
- Patient privacy and dignity was not always protected. Specifically, when patients were in the POD facility and the corridors. Patients privacy and dignity was not protected at the booking in desk and when speaking to the visual assessment clinician nurse. Patients and their relatives could hear conversations which were personal and private.
- Not all patients using the service had had all their relevant clinical assessments carried out. Patients waited on trolleys in the ambulance corridor for long periods of time without having had a tissue viability assessment or a falls assessment.

However,

- Staff cared for patients with compassion. Staff were friendly, professional and caring even when under extreme pressure.
- There were processes to escalate concerns regarding patients' safety and care or treatment once they were admitted to the department.
- Patients admitted to the department and in the ambulance assessment area had evidence that regular clinical observations had been undertaken, and that an accurate early warning score had been recorded.
- Although there were gaps in the nurse staffing rota, the emergency department was staffed with nurses who had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.
- The service had sufficient quantities of suitable equipment which was easy to access and ready for use.
- Staff and managers across the emergency department promoted a positive culture that supported and valued each other. Staff were respectful of each other and demonstrated an understanding of the pressures and a common goal.
- The emergency paediatric department was managed by competent and skilled consultants in paediatric emergency medicine. Nurses in the department had the right skills knowledge and experience to keep children safe.

Summary of findings

- Children attending the department were clinically reviewed and triaged in a timely way.

Following our inspection, we issued the trust with a section 29A Warning Notice to significantly improve the safety and care of patients by 4 March 2020.

Importantly, the trust must:

- The trust must ensure that ambulance handovers are timely and effective.
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments.
- The trust must ensure that patients receive medical and speciality reviews in a timely manner.
- The trust must ensure all risks are assessed to patients using service, particularly the risks of developing pressure ulcers while waiting on trolleys for long periods in the ambulance corridor.
- The trust must ensure that the dignity of all patients using the service is always protected. This includes specifically the booking in process at the front desk and when speaking to the visual assessment clinician nurse, and for all patients cared for in the ambulance corridor.

In addition, the trust should:

- The trust should ensure that there are enough consultants working in the department to keep patients safe, even in times of overcrowding.
- The trust should ensure that its nurse vacancies are fully recruited to in order to keep patients safe, even in times of overcrowding.
- The trust should address the cultural challenges in the department and ensure there is a cohesive and multi-disciplinary approach to the management of patients in the department.
- The trust should consider improving emergency department consultant representation at board level.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Requires improvement



Summary of each main service

We carried out an unannounced focused inspection of the emergency department in response to intelligence we had about the department which was associated to a potential increase in risk. We did not inspect any other core service or wards at this hospital. We did not cover all key lines of enquiry.

At the time of our inspection, the department was under adverse pressure with significant overcrowding. Whilst staff did their best to care for patients with compassion, we found some patients had delays to initial assessments and timely treatments. The trust was implementing a range of actions to reduce overcrowding.

Summary of findings

Contents

Summary of this inspection

	Page
Background to Leicester Royal Infirmary	6
Our inspection team	6
How we carried out this inspection	6
Information about Leicester Royal Infirmary	6

Detailed findings from this inspection

Detailed findings by main service	9
Outstanding practice	20
Areas for improvement	20

Summary of this inspection

Background to Leicester Royal Infirmary

University Hospitals of Leicester NHS Trust serves over one million residents of Leicester, Leicestershire and Rutland. The trust provides specialist treatment and services in cardio-respiratory diseases, extra corporeal membrane oxygenation (ECMO), cancer, and renal disorders to a further two to three million patients from the rest of the country.

Services are spread over Leicester General Hospital, Glenfield Hospital and Leicester Royal Infirmary, with the Children's Hospital on site at Leicester Royal Infirmary. The trust works closely with partners at two local universities in medical education for doctors, nurses, and other healthcare professionals.

(Source: Acute Routine Provider Information Request – Context acute tab)

Leicester Royal Infirmary is close to Leicester city centre and is part of the University Hospitals of Leicester NHS Trust. It serves Leicester, Leicestershire and Rutland with a population of diverse cultures. The hospital has over 1,000 beds and provides Leicestershire's only emergency department.

We previously inspected the at Leicester Royal Infirmary in September 2019.

Our inspection team

The inspection team comprised of one CQC inspector, and three specialist advisors. Two of the specialist advisors were consultants in urgent and emergency care, one of whom is also employed as a CQC national

professional adviser in emergency care, and an emergency department nurse. The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

How we carried out this inspection

This was a focused unannounced inspection of the emergency department at Leicester Royal Infirmary 27 January 2020. At the time of our inspection, the emergency department was operating under NHS England Operational Pressures Escalation Levels (OPEL) level 4.

We did not inspect the whole core service therefore we have not rated against the effective, caring or well-led key

questions. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology. Although we did not consider all key lines of enquiry, we have issued a range of requirement notices and therefore rated the safe and responsive key questions as requires improvement.

Information about Leicester Royal Infirmary

Leicester Royal Infirmary is close to Leicester city centre and is part of the University Hospitals of Leicester NHS Trust. It serves Leicester, Leicestershire and Rutland with a population of over one million people from diverse cultures. The hospital has over 1,000 beds and provides Leicestershire's only emergency department. The emergency department (ED) saw approximately 260,000

patients from July 2018 to August 2019, and approximately 66,000 of these patients were children. It is one of the busiest ED's in the UK. The department is staffed 24 hours a day, seven days a week by consultants, senior and junior doctors and advanced clinical practitioners (ACPs).

Summary of this inspection

Leicester Royal Infirmary has a co-located adult and separate children's emergency department. The service also has an urgent primary care provider integrated within the department. It is close to the emergency decisions unit, children's short stay unit and medical assessment units.

There is a GP assessment unit (GPAU) providing same day emergency care, open from 8am to 12am seven days a week. There is also an ambulatory deep vein thrombosis and transient ischaemic attack service.

Emergency nurse practitioners (ENPs) provide a nurse led service within minor injuries, 24 hours a day, seven days a week. An acute medical team, led by a senior doctor, are present 24 hours a day, seven days a week, alongside a frailty in-reach multi-disciplinary team for up to 10 hours per day.

The children's emergency department is a single front door for all children with emergency presentations, operated jointly between emergency paediatric physicians and acute paediatric consultants. A multi-disciplinary team supports the medical workforce across the adult and children's emergency department.

The nursing workforce is led by a senior nurse 24 hours a day, seven days a week, with matron presence. The new build means patients are now cared for in a purpose-built department with all diagnostic services being integrated within the footprint of the department.

(Source: Acute Routine Provider Information Request – Context acute tab)

The newly built ED opened in April 2017 with the adult area comprising of a 12 bedded emergency room (ER), 32 individual major bays, four of which have been designed for those with mental health needs or living with dementia, an 11 bedded ambulance assessment area with separate entrance and eight triage rooms.

In addition to the ambulance assessment area, the ED had recently expanded into a purpose-built pod where patients are dropped off by ambulances when the department is full and are cared for by ambulance staff. The aim of the pod is to allow ambulances to get back out onto the road to attend emergencies as quickly as

possible. The pod was staffed by an NHS paramedic and ambulance technicians from a private ambulance company. The pod was closed to ambulance patients at the end of February 2020.

The paediatric ED comprises of 10 major areas (including three high dependency areas), four primary care rooms, five streaming rooms and six minor injury rooms.

The blue zone within the adult ED provides a large seating area with access for all walking patients and 23 cubicles in total. Patients are assessed in this area and can either be seen by a primary care doctor or signposted to a different area of the department which is more appropriate to their needs. There is direct access when required in the blue zone to a small parts x-ray machine to identify fractures.

A 12 bedded children's short stay unit (CSSU) is located with direct access from the paediatric ED. Two of the bays in CSSU have been designed for younger people with mental health needs.

Both adult and paediatric departments have direct access to an area containing two computerised tomography (CT) scanners and three plain film x-ray machines. A small laboratory is also available in the department providing support services to clinicians who require urgent tests to be undertaken to aid diagnosis. Both these facilities are open 24 hours a day.

In addition, the hospital provides an emergency decision unit (EDU) for patients who require, for example, further observations, treatment for a short period of time or transport to return home.

The GP admissions unit (GPAU) offers six trolley spaces and a chaired area for those patients referred to Leicester Royal Infirmary by GP's who are being considered for emergency admission. The unit aims to provide rapid assessment, diagnosis and treatment on the same day without overnight admission where possible. It is open from 8am to 8pm, seven days a week



A specialist eye emergency department operates from 8.30am to 4.30pm Mondays to Fridays and 8.30am to 12.30pm Saturday, Sunday and Bank Holidays.

We visited all areas of the ED during our inspection. We spoke with 15 members of staff, 8 patients and their

Summary of this inspection

relatives. We looked at 28 sets of patient records. We also spoke with the leaders of the department, the lead consultant, the head of emergency nursing and the director of operations.

Urgent and emergency services

Safe	Requires improvement 
Effective	
Caring	
Responsive	Requires improvement 
Well-led	

Are urgent and emergency services safe?

Requires improvement 

As this was a focused inspection, we have not inspected the whole of this key question.

Our rating of this service went down. We rated it as requires improvement because:

- There were delays in ambulance handovers and resultant delays in assessment and treatment for some patients due to overcrowding.
- Whilst the service mostly had suitable premises, there were insufficient cubicles to accommodate all the patients in the department when it was overcrowded. Patients were being cared for in a corridor at the time of the inspection.
- Triage times were not completed in line with guidance. Some patients waited a considerable time to be assessed due to overcrowding.
- Whilst risks to patients were assessed and their safety monitored and managed, not all patients received treatment in a timely manner due to overcrowding.
- ED consultants told us they needed more senior doctors to keep the patients safe when it was overcrowded.

However,

- There were processes to escalate concerns regarding patients' safety and care or treatment once they were admitted to the department.
- Patients admitted to the department and in the ambulance assessment area had evidence that regular clinical observations had been undertaken, and that an accurate early warning score had been recorded.
- The paediatric ED was managed by competent and skilled consultants in paediatric emergency medicine.

- Children attending the department were clinically reviewed and triaged in a timely way.

Environment and equipment

The design, maintenance and use of facilities and premises did not always keep people safe from avoidable harm, and there was insufficient space to accommodate all the patients in the department during periods of high demand.

The design of the environment followed national guidance. The adult and children's emergency department (ED) were purpose built in 2017. The facilities complied with Health Building Note 15-01; Accident and Emergency Departments. Adult and children's ED were separate departments, therefore there was audio and visual separation from each other.

The environment inside the ED was light and spacious and promoted a calm atmosphere which had a positive impact on patients. However, during our inspection, the waiting room was full and appeared overcrowded with some patients and relatives standing up in the walkways.

There were insufficient cubicles to accommodate all the patients admitted to the department when it was overcrowded. Patients were frequently kept waiting to enter the department on the back of ambulances. Patients were also being cared for in the ambulance assessment area corridor throughout our inspection and in an outside overflow 'ambulance escalation pod' (POD).

When the ambulance assessment area was full, overflow patients who met a certain criterion, were cared for in the POD. This allowed ambulances to leave the hospital sooner and respond to emergency calls. The POD was a modular temporary structure built outside of the ED, alongside the ambulance arrival bays. It consisted of eight trolley spaces, and two spaces which were used for

Urgent and emergency services

chair patients. However, the standard operating policy (SOP) for the POD excluded patients who were fit to sit. Information provided by the service showed from 3 January to 9 January 2020, there had been six occasions recorded when fit to sit patients had been cared for in the POD. This meant practice within the POD was not always compliant with the agreed SOP.

Frail elderly patients were being cared for in the POD. The POD did not feel warm enough to comfortably accommodate immobile patients. Ambulance staff told us it sometimes felt a lot warmer than during our inspection. Blankets were available for patients. Bays had disposable curtains which were used to increase visual privacy. However, the building acoustics and ergonomics were such that audial privacy was not possible and the environment was not conducive to providing personal or intimate care. There were no bathroom facilities in the POD. We were told patients would be assisted to the bathrooms inside the hospital, on a trolley if they were unable to walk independently. Alternatively, patients would be provided with commodes and bedpans to use in the bed space.

Emergency equipment, clinical waste disposal bins a mobile handwashing facility was available in the POD.

The ambulance assessment corridor was used to care for an extra four patients. Patients in this area were on trolleys. There was room for relatives on one or two chairs. The corridor was spacious, but staff patients and visitors frequently walked through the corridor to access other areas of the department. This made it difficult for patients to rest while they waited to be seen. It was not an appropriate environment to keep patients for a long time.

Staff provided corridor patients with drinks and snacks, however there was no table or shelf facilities. Therefore, patients had nowhere to place a cup while they ate.

Some conversations between staff and patients treated in the corridor could be heard by those nearby. It was difficult for patients to share personal or confidential information without being overheard by other patients and relatives. Staff told us patients were taken to assessment rooms if consultations or procedures such as ECG's were required.

The SOP for use of the ambulance assessment area corridor included the use of screens to provide some privacy for patients. However, during our inspection these screens were not in use.

Walk in patients were booked in at the main reception area. There were several reception staff on duty day and night. The reception desk was an oval space with seating for booking in staff and a visual assessment clinician (VAC nurse). Patients queued prior to presentation at the reception desk. During our inspection, the queue went outside of the hospital entrance doors. Patients were not advised to stand back to offer privacy to the patient in front. There was a risk personal and private information could be overheard by other patients using the service.

After patients had registered, they queued to see the VAC nurse. The VAC nurse asked patients for details about their complaint. This information could be overheard by other patients using the service. This was raised with senior staff as a concern during our inspection in September 2019. We were told the department was trying to improve patient privacy and dignity during the booking in process and during the VAC nurse consultation, and that it was on the departments risk register. However, the issue remained a concern during this inspection.

Assessing and responding to patient risk

There were delays in off-loading ambulances and resultant delays in assessment and treatment for some patients due to overcrowding.

Patients arriving by ambulance when the ambulance assessment area was full remained in the care of the ambulance service until they had been handed over to the emergency department (ED) staff inside the department.

Patients were kept on the back of ambulances until they could be admitted to the ambulance assessment area, the POD, or other appropriate area of the ED. Guidance from Royal College of Emergency Medicine (RCEM) recommends patients should be offloaded from ambulances within 15 minutes of their arrival at an ED. Trust board papers report that in November 2019, 33% of ambulance handovers were completed within the national standard of 15 minutes.

Patients waiting under the care of an ambulance crew for one hour or more are called a black breach. From the

Urgent and emergency services

period of 2 December 2019 to 26 January 2020 performance in relation to ambulance handovers was mixed, ranging from 10% to 32% of ambulances waiting over 60 minutes to offload. The most significant performance issues took place during the following periods:

- From 2 to 8 December 2019 16% of ambulance were waiting over 60 minutes to offload.
- From 16 to 22 December 2019 29% of ambulances were waiting over 60 minutes to offload.
- From 6 to 12 January 2020 32% of ambulances were waiting over 60 minutes to offload.

From 1 January to 26 January 2020, the average number of black breaches was 36 per day. Most black breaches occurred on 3 January 2020, when there were 98 breaches, and the least occurred on 23 January 2020, when there were 0 breaches.

On 27 January 2020 at 15:08, and when the ambulance assessment area was full, there were four patients being cared for in the corridor and seven ambulances waiting to offload. At this time, the longest offload time for those seven ambulances was 58 minutes. The longest wait for a patient in the corridor was four hours and 31 minutes.

Concerns regarding delays in ambulance turnaround times were raised with the trust in November 2019. The trust had outlined a series of actions to improve flow in the emergency department. However, we saw that these actions had little impact on the delays in the department and did not resolve the risks associated with those delays.

Data submitted by the trust, following the inspection, showed the emergency department had 3.5% more ambulance handovers in January 2020 compared to January 2019. This was an increase of 208. By January 2020, the trust had seen 11 consecutive months of ambulance conveyances higher than the mean indicating a special cause upturn in demand. Since January the trust have seen an improvement in the percentage of ambulance handovers in under 60 minutes.

Trust board minutes from 6 January 2020 identified shortages of medical beds in the trust as making it 'impossible to achieve handover performance'. Nurse vacancies throughout the hospital was also identified as a restriction on meeting targets.

Walk in patients were not always assessed or given treatment in a timely manner. Risks associated with the long delays in the triage and assessment of walk in patients in the emergency department were not mitigated when the ED was overcrowded. Standards set by the RCEM state an initial clinical assessment should take place within 15 minutes of a patient's arrival at hospital.

We reviewed the clinical assessment times of 16 patients attending the emergency department on 27 January 2020. The shortest time to triage was recorded as 0 minutes. The longest time was recorded at two hours 30 minutes, although two of the 16 patients were still awaiting triage at the time of our review. The average time to triage was 62 minutes. This does not meet the recommended standards for emergency care. We were concerned patients were at risk of deterioration while waiting for a full assessment.

At the time of our inspection, staff in the emergency department were unable to provide evidence of the percentage of patients being triaged within 15 minutes of their arrival. However, the trust did collect average times of compliance to triage within a 30 minutes timeframe. We saw that from 9 September 2019 to 13 January 2020, the trust did not meet this target in any week, and that average time to triage had been over 60 minutes every week.

Walk in patients were viewed on arrival by the visual assessment clinician (VAC nurse). The VAC nurse allocated each patient a dynamic priority score (DPS). DPS scores were one, two or three, with one being the most urgent. During our inspection we observed that most patients were allocated a score of two or three, and were seen in order of DPS priority, and time of arrival. However, the DPS score did not mitigate the risks of delayed triage, especially when the waiting area was full, and it was difficult to observe all the patients in the area adequately. There was a risk patients would deteriorate post VAC nurse review and prior to triage, and this deterioration would not always be picked up early enough to prevent patient harm.

The waiting room was full during part of our inspection. There were very few chairs available and patients were standing in the open areas.

Urgent and emergency services

Admitted patients in the emergency department had regular assessments and were monitored using an early warning scoring system to identify deteriorating patients. Patients were escalated appropriately. However, patients in the ambulance corridor did not have all of their risk assessments completed.

On admission, adult patients were assessed using the NEWS2 scoring system which included a baseline assessment to determine and monitor the severity of the patient's condition. This is in line with good practice guidance from the National Institute of Health and Care Excellence (NICE), Clinical Guidance (CG) 50: 'Acutely ill adults in hospital: recognising and responding to deterioration' (2007).

The NEWS score determined the degree of illness and was based on the patient's vital signs including respiratory rate, oxygen saturation level, blood pressure and heart rate. The score was highlighted on the initial assessment as an early warning score (EWS) which helped to identify patients most at risk of deterioration or sepsis. Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs and action is required quickly.

Patient observations were recorded electronically in all areas of the department. The electronic track and trigger system (e-observations) calculated the EWS scores and set frequency of observations and any escalation response.

The trust had an established sepsis team who had access to EWS's on all patients in the trust and were able to quickly track patients whose clinical observations could indicate sepsis. Additionally, sepsis six care bundle posters were displayed throughout the ED to remind staff of their responsibilities and what they should do if they suspected sepsis.

All records we reviewed during our inspection had evidence of regular and appropriate EWS. We saw two patient's records who were at risk of developing sepsis. Both patients had been identified and had the sepsis six care bundle instigated. The sepsis six care bundle is a resuscitation bundle designed to ensure basic interventions are given within the first hour to patients who may be at risk of developing sepsis. It includes the

administration of IV antibiotics and collection of blood cultures, among other things. Prompt delivery of the sepsis six bundle can help prevent much more extensive treatment and reduce patient mortality.

The ED audited its response to sepsis screening and time to antibiotic administration every month. From June to December 2019, compliance ranged from 81% to 87%. Where patients had not been screened or had not received appropriate administration of IV antibiotics within one hour, an ED consultant carried out a harm review. From 22 November to 9 December 2019, five reviews had been done and no harms had been identified. However, some patients with suspected infections waited a long time before being given antibiotics. This included one patient who waited 12 hours before being prescribed antibiotics, and who had been on the back of an ambulance for more than three hours, and a patient who was immunocompromised, who waited nearly six hours for their antibiotics. We were told that compliance was improving, and no harms had been identified so far.

In the children's ED, VAC nurses were paediatric trained, and children were assessed using the paediatric observation priority score (POPS). POPS is a bespoke emergency and urgent care checklist which quickly scores (between 0-16) acutely ill children on a combination of physiological, behavioural and risk identifiers and an assessment of the child's pain. This enabled staff to assess, prioritise and treat acutely ill children, and manage risk in busy clinical areas. Paediatric early warning scores were also used to identify children whose condition was deteriorating.

Patients arriving by ambulance were assessed in either the emergency room if their condition was serious, or in the ambulance assessment area if they were stable. When the assessment area was full, patients remained on the ambulance until a cubicle was available, or the POD was opened. Consultants or advanced care practitioners reviewed patients while they were on the back of an ambulance. Consultants, or ACP's were responsible for deciding which patients were suitable to wait in the POD.

Nurses commenced risk assessments on patients in the ambulance assessment area quickly and this included early warning scores to determine and monitor the severity of each patient's condition. However, patients cared for in the ambulance corridor did not have all of

Urgent and emergency services

their risk assessments completed. During our inspection, we saw that two patients had been in the corridor for seven hours. The trust SOP for use of the ambulance assessment area, which included the corridor area, required all patients to receive pressure area care. We observed that zero out of four patients cared for in this area had their pressure area care assessments or falls assessments completed. One of the patients in the corridor had been taken to hospital because of a fall. There was a risk patients in the corridor could suffer harm, for example, develop a pressure ulcer, due to the lack of risk assessments undertaken. We did not see evidence of actual harm during our inspection. Ambulance staff working in this area said they did not normally record their interventions on the ED admission booklet, although they did record when food and drink had been provided.

There were processes to escalate concerns regarding patients' safety/care or treatment. The trust had policies for responding when demand exceeded capacity in the ED. We saw that the trust escalation policy was in operation during our inspection.

The ED had a patient management screen in each of its clinical areas which provided an overview of the number of patients in ED, DPS scores, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting, and the longest ambulance crew wait. The patient management system allowed managers to see where risks were in the department.

Risks were discussed at bed meetings throughout the day. This helped facilitate any staffing changes required to manage the flow in the department and helped with the movement of patients throughout the hospital, and with community partners and ambulance services.

Nursing staffing

There were nurse vacancies in the emergency department (ED), although during our inspection these were mitigated and there was enough nursing staff with the right qualifications, skills, training and experience to mostly keep patients safe from avoidable harm. There were long waits for nurse triage.

During our inspection, there were 22 nurses working in the adults ED, against a target of 26, and there were eight

nurses working in the paediatric ED, against a target of 11. Senior nurses told us gaps in nursing were covered by using some of the advanced nurse practitioners differently and by being creative with the available staff they had, including with the use of health care assistants. In the paediatric ED, two beds were closed to maintain safe staffing levels. During our inspection, risks to nurse staffing had been mitigated.

The adult ED nurse vacancy rate was 14%, at the time of our inspection and the paediatric ED vacancy rate was 25%. Senior nurses told us they were continuously recruiting. Bank and agency staff were used regularly. We were told most agency staff used were regular staff who knew the department and were experienced ED nurses. New bank and agency staff underwent a local induction in the department.

NHS and private ambulance staff looked after patients in the ambulance assessment corridor and in the POD. These staff were additional to ED numbers.

The nurse in charge adjusted staffing levels daily in each area of the ED according to the needs of patients. Staffing level reviews were undertaken daily, and nurses from other wards and departments in the hospital worked in ED when required.

The paediatric ED had a minimum of two children's nurses on each shift in line with the 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings' document titled, "Standards for Children and Young People in Emergency Care Settings" (2012) which recommends that clinical staff should have minimum competencies including recognition of the sick or injured child, basic life support skills, and the ability to initiate appropriate treatment. In addition, some adult trained nurses had undertaken additional training beyond paediatric resuscitation training, to provide them with the skills required to recognise deteriorating children. Children's nurses also undertook competencies in adult nursing.

Medical staffing

Whilst there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to

Urgent and emergency services

provide the right care at the time of the inspection, senior doctors told us they needed more consultants in order to keep the department safe when it was overcrowded.

Consultants were in the ED 8am to 2am every day which met the Royal College of Emergency Medicine (RCEM) recommendation of 16 hours consultant presence every day. Nurses and doctors told us consultants rarely left the department at 2am, and regularly worked longer hours. An on-call consultant covered the out of hours period seven days a week. There was also an allocated consultant for the ED patients admitted to the emergency decisions unit (EDU).

At the time of our inspection there were 18 whole time equivalent consultants (WTE) working in the adult ED. A senior member of the medical team told us they required 40 WTE consultants to run the department safely. Although we did not see any evidence of harm to patients during our inspection due to consultant shortages. However, some patients waited a long time to be seen, treated and admitted or discharged.

A doctor from the acute medicine speciality team worked in the ED from 8am to 8pm Monday to Friday. This role helped speed up patients' admission to hospital and also increased the number of patients who could be treated within the department and avoid an unnecessary admission to a hospital bed. Five paediatric consultants worked in the paediatric ED. Consultants from the adult department provided cross cover for paediatric ED when required. Paediatric consultants worked from 8am to 1am and registrars with specialist training in paediatric medicine covered out of hours. Two staff grade doctors specialising in paediatrics were also available and extra senior paediatric support was always available from the children's ward if required in an emergency.

Are urgent and emergency services effective?
(for example, treatment is effective)

As this was a focused inspection, we did not inspect against this key question.

Are urgent and emergency services caring?

As this was a focused inspection, we have not inspected the whole of this key question.

We did not rate caring.

- Staff cared for patients with compassion during the inspection. Staff were friendly, professional and caring even when under extreme pressure due to overcrowding in the department.
- Feedback from parents and relatives confirmed staff treated them well and with kindness.
- Staff tried to maintain patient privacy and dignity in times of overcrowding.

However,

- Patient privacy and dignity was not always protected due to overcrowding.
- Some patients were cared for in the corridor for long periods.

Compassionate care

Staff were professional, friendly and caring towards patients during our inspection. However, patient privacy and dignity was not always protected.

Staff were friendly, professional and caring. Patients we spoke to told us they were being well cared for, despite the ED staff being very busy. Nursing staff tried to ensure patients were comfortable while they waited for treatment in the emergency department (ED). Additional blankets, pillows and refreshments were offered to try and enhance comfort.

Patient privacy and dignity was not always protected in the ED waiting room and at the reception desk. Patients at the booking in desk and at the visual assessment clinician (VAC nurse) could be overheard by other patients and visitors using the service. There was a risk conversations which included private and sensitive information would be overheard.

Understanding and involvement of patients and those close to them.

Staff involved most patients and those close to them in decisions about their care and treatment but

Urgent and emergency services

some patients and relatives waiting in the ambulance assessment corridor told us they did not know what they were waiting for, or what their plan of care was.

Most patients told us they generally felt informed about their care and treatment and knew what they were waiting for in the department. Some patients and their relatives cared for in the ambulance assessment corridor told us they did not know what they were waiting for, or what the plan for their care and treatment was. One relative who had been in the department for several hours told us they had been moved from the corridor, into a cubicle, then back out into the corridor again and then for a scan before coming back to the corridor and said that they had no idea if their relative was going to be admitted or discharge, or when they would next see a doctor.

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

Requires improvement 

As this was a focused inspection, we have not inspected the whole of this key question. Our rating of this service went down. We rated it as requires improvement because:

- Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.
- Staff did not always maintain the privacy and dignity needs of patients cared for in the corridor or POD due to overcrowding.

Service delivery to meet the needs of local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served.

Frail elderly patients were cared for in the POD which had no accessible bathroom facilities and meant patients privacy and dignity could not always be protected. The POD had no accessible toilets and the nearest toilets were inside the ED. Frail elderly patients were cared for in

the POD. Some of these patients might have difficulty getting off the trolley and being taken outside to access the ED toilets. Patients who were unable to access the toilets used bedpans and bottles or a commode by the bedside. From 2 January to 10 January 2020, between 13 and 28 patients were cared for in the POD each day. The total number of patients cared for in the POD during this time was 177, and 66% of these were in there for two hours or more.

Paper curtains were available around each trolley in the POD. However, the POD facility acoustics did not ensure patient privacy and dignity at all times. It was not always possible for staff to have private conversations with patients cared for in either the corridor or the POD without being overheard.

Staff did not always maintain the privacy and dignity needs of patients cared for in the corridor or POD due to overcrowding. Some of these issues were due to overcrowding but there were screens available to use on the corridors which were not in use at the time of our inspection. Ambulance staff told us the patients in the corridor were moved to a cubicle in the ambulance assessment area if interventions were required, for example an ECG.

Access and flow

Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.

There were systems to manage the flow of patients through the emergency department (ED) and to discharge patients or to admit them to the hospital. Senior hospital staff and managers could assess the IT system and see the length of time each patient had been in the department, who had been referred to a speciality doctor, and required admission. The system allowed them to have an overview of bed availability and the flow of patients coming into the ED. This was discussed at regular bed meetings throughout the day and plans were made. However, despite these measures, demand for ED services outstripped capacity, and some patients had long delays in accessing emergency care and treatment.

There was insufficient flow in the department to see, treat, admit or discharge patients from the hospital. At approximately 6.30pm on 27 January 2020, there were

Urgent and emergency services

185 patients in the department, and 105 of these were waiting to be seen. We were told there were 29 patients waiting to be admitted to a hospital bed at this time, however there were no beds available across the trust. Senior managers told us clinical staff were working with wards and departments to find beds for these patients.

During our inspection, we looked at the waiting times for patients awaiting a doctor's review. We looked at seven patients in the adult ED and three patient records in the emergency room. No delays were identified in the emergency room, however adult patients in the ED waited an average of five hours 24 minutes before being seen by an ED doctor. The longest delay was six hours and three minutes, and the shortest delay was recorded as three hours and 16 minutes.

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, known as the Emergency Access Standard (EAS).

From January to December 2019, the trust consistently failed to meet the EAS standard. In December 2019, performance was 61%, which was worse than the England average of 81%.

On the day of our inspection, 27 January 2020, at approximately 18.30, there had been 124 four-hour breaches. On 26 January 2020, the trust reported 235 four-hour breaches in 24 hours.

Some patients waited more than 12 hours before a decision about their care was made. In December 2019, 24 patients waited 12 hours or more and in January 2020, 18 patients waited 12 hours or more. Once a decision to admit had been made, the average length of time a patient waited for a bed from November 2019 to January 2020, was 3 hours 53 minutes.

ED consultants were unable to make the decision to admit some types of patients into hospital. A consultant from the relevant speciality, for example, orthopaedics, had to review and accept the patient prior to a decision to admit (DTA) being made. This delayed the admissions to hospital beds and meant some patients waited in the ED for long periods of time. The service was unable to

provide data on the length of delays specifically due to waits for speciality review. The trust told us it was working on pathways in the trust as part of its action plan to reduce delays in the department.

ED escalation levels were determined by the regional health economy Operational Pressures Escalation Levels (OPEL) management system. OPEL levels were graded one to four. OPEL one was normal working, and four was the department was under severe pressure, and unable to sustain business as usual. The ED was operating at OPEL four on the day of our inspection, which meant the department was unable to meet the four-hour performance and patients were being cared for in an 'overcrowded and congested department which could lead to patient care and safety to be compromised'.

The ED followed their escalation policy 'Capacity and Flow Escalation Policy and Whole Hospital Response to Emergency Care Demand' at times of increased demand. The policy included steps to be taken when each level of OPEL escalation was reached. During our inspection the trust told us it was carrying out the actions listed in the policy including, for example, cancelling all elective surgery (excluding urgent cancer surgery) to increase bed availability, and senior staff were working with wards to identify patients suitable for discharge, and that all flexible extra capacity beds were opened. Senior ED staff told us the hospital did 'board' patients when necessary, however at the time of our inspection, we were told there were no patients currently boarding on site. 'Boarding' is a term used to describe patients who are awaiting admission, but who are either, still in the ED beyond agreed service standards, or who are on a ward, but who are not in a properly configured bed and bed space.

Specialty doctors were unable to respond to all ED patients in a timely manner. We did not identify any delays in speciality doctors attending the ED during our inspection, but senior staff told us there were delays in some speciality doctors reviewing their patients in the ED. Speciality review delays were not reported separately. We were told this had led to delays in making decisions about a patient's care which further contributed to overcrowding and reduced flow in the department. However, consultants in ED told us these delays did not prevent patients receiving their initial treatment, which was initiated by ED staff.

Urgent and emergency services

From September 2019 to January 2020, we saw two incidents had been reported which related to delays in orthopaedic doctors attending the ED to review their patients. However, doctors also told us there were sometimes delays in accessing specialists in urology and gynaecology. Staff said they did not always report delays as incidents due to the workload in the department.

The trust had a policy agreement for the timeliness of responses from speciality doctors to review patients in ED. The Inter-Speciality Professional Standards document said that specialities must review their patients in ED within 30 minutes of receiving the referral. During our inspection, we were told that not all speciality doctors reviewed their patients within 30 minutes, and that some patients waited many hours for a specialist review. The trust was unable to provide specific information on these delays.

Are urgent and emergency services well-led?

As this was a focused inspection, we have not inspected the whole of this key question. We did not rate well led.

- Local leaders and managers had the right skills and abilities to run the service and were visible in the department.
- Staff and managers working in the ED promoted a positive culture that supported and valued one and other. Staff were respectful of each other and demonstrated an understanding of the pressures and a common goal.
- The service monitored activity and performance and used data to identify areas for improvement, however, the department's performance against national targets was deteriorating.
- Plans were being implemented to ease overcrowding in the emergency department (ED), however at the time of the inspection these plans had not reduced overcrowding and patients waited a long time to be seen.

However,

- ED consultants had not been fully involved in the implementation of the POD and were not fully consulted prior to its introduction. Concerns raised by consultants had not been fully addressed.

- Consultants in ED did not have full admission rights for all types of patients attending ED. This led to more patients being in the department for longer, whilst specialist teams were consulted over admissions.
- The ED consultants did not have formal direct access to the senior leadership team. The ED was not represented at board level by an emergency department consultant.

Leadership

Local leaders and managers had the right skills and abilities to run the service and were visible in the department.

Leadership in medical and nursing staff was clear, positive and collaborative. Leadership for each clinical area was clear and staff knew who to ask if they needed advice or support. The nurse in charge of the shift and the head of nursing were kept updated on issues and had oversight of all activity. Nurses told us doctors in the department were always supportive and responsive.

ED consultants told us they were represented at board level by a doctor who was not an ED consultant. This meant ED consultants did not have a formal direct access route to the board and that decisions could be made at board meetings about the department without an ED consultant being present. Consultants told us they were able to approach the medical director informally on any issue, however, formal representation and feedback to the senior leadership team was via a doctor from another speciality.

Vision and strategy for this service

The service had a documented vision for what it wanted to achieve. Plans were being implemented to ease overcrowding in the department were in development with involvement from staff, patients, and key groups representing the local community. However, at the time of our inspection, the department remained under extreme pressure.

There was a trust wide plan for improving the flow of patients through the hospital. This included the opening additional beds for general medicine patients.

Urgent and emergency services

The service leads had a clear vision of what they needed to do to improve flow. Trust wide, this included working on patient pathways in ambulatory care and the provision of assessment trolleys in the medical assessment unit for direct admissions (GP expected).

NHS Improvement was supporting the service with measures to reduce ambulance turnaround times at the hospital and this had included the introduction of the POD area.

Governance, risk management and quality measurement

The service had a systematic approach to continually monitor the quality of its services.

However, although the service monitored activity and performance and used data to identify areas for improvement, performance in the ED remained lower than the national average, and patients waited a long time to be seen, treated, and admitted or discharged.

Consultants in the department told us the plans regarding the introduction of the POD had not been fully discussed with them prior to its arrival and opening. We were told decisions about who would be responsible for patients in the POD had not included discussions with ED consultants.

Consultants told us they were concerned about the governance surrounding the care of the patients in the POD. We were told it was the consultant's responsibility to decide the suitability of ambulance patients for placement in the POD, and that they therefore felt they had overall responsibility for the safety of that patient. However, consultants were concerned that the care of these patients was passed to a third party and beyond their control. Consultants were concerned that in the event of a serious incident, staff working in the ED might be called to account for care provided by another organisation.

The POD standard operating procedure excluded patients who were fit to sit. However, two extra spaces were included in the design of the POD to accommodate fit to sit patients. Fit to sit patients had been placed in the POD.

When the department was overcrowded, the risks to patients of deteriorating unnoticed in the waiting room while awaiting a full assessment had not been fully

mitigated. The visual assessment clinician nurse and other clinicians working in or near the waiting room were unable to safely monitor all the patients waiting to be seen.

Consultants did not have full admission rights for all types of patients using the service. This meant some patients who had been assessed by an ED consultant as requiring a hospital admission, had to wait for a speciality doctor to carry out their own assessment and make the decision to admit. This caused delays to patient admissions and meant patients could not access the most appropriate environment for their care, in a timely way. This also impacted on flow in the ED department as it delayed the decision to admit (DTA). Time from DTA to accessing a hospital bed is a collected and monitored nationally. Delays in starting the DTA meant some very long delays in the department would go unreported.

The risks to patients being cared for in the ambulance of developing a pressure ulcer were not recognised or mitigated. Staff working in this area did not carry out risk assessments and told us they did not complete the ED paper booklet which included a risk assessment for tissue viability.

Real time data relating to performance was clearly available in the ED. Performance reports were discussed daily at bed meets and reported at monthly board meetings. Staff openly discussed performance and what it meant for patients. Staff knew the main risk areas in the department and the actions needed to keep patient safe from avoidable harm

Regular audits were undertaken in the department and results were used to drive improvements. This included audits on sepsis, escalating deteriorating patients and nursing documentation audits as well as data submitted to the Royal College of Emergency Medicine audits. However, performance reports and audits had not addressed the privacy and dignity issue at the booking in desk, at the time of our inspection.

The trust acknowledged that at the time of the inspection it was very busy in the emergency department. The trust told us that there were agreed escalation actions and provisions made to support the department during periods of extreme demand. There was provision to accommodate four patients in the cohorting area (referred to as 'the corridor' between ambulance

Urgent and emergency services

assessment area and the hot lab). The trust said there was good provision of screening to maintain privacy and dignity. There were policies, procedures and staffing establishment in place to ensure patients were safe, their care was effective and their experience was good, therefore maintaining a high quality of service. This was a period of extreme system-wide demand.

After the inspection, the trust told us that a multi-agency, multi-disciplinary approach had been taken to managing the extreme demand across the urgent and emergency care system. A collaborative system-wide risk assessment had been undertaken regarding the implementation of an ambulance handover hub (POD). The comparative risk assessment identified that the risks associated with not introducing cohorting using the POD outweighed the risks associated with implementation. It had been therefore recommended that the system partners supported implementation of cohorting using the POD and agreed to monitor the impact. A copy of this risk assessment signed by all stakeholders and the SOP agreed with system partners was provided. The agreed staffing establishment and capacity of the POD was to accommodate eight patients. At the time of the inspection, there had been four patients in the POD.

Culture within the service

Staff and managers working in the ED promoted a positive culture that supported and valued one and other. Staff were respectful of each other and demonstrated an understanding of the pressures and a common goal.

Nurses and doctors worked collaborative to provide the best care they could to patients attending their ED. However, when the department was overcrowded, there was not enough staff to carry out all of the tasks required to keep patients safe at all times.

Doctors told us they needed more senior doctors in the department to run a safe and effective service. Nurse leaders were concerned about the level of vacancies in the department and told us they had closed paediatric beds due to nursing shortages.

Nurses and doctors spoke very positively about the clinical leads in their department and told us they were very visible, approachable and supportive.

Consultants were concerned that decisions were made about their department by the senior leadership team without their full involvement and told us there had been a lack of engagement with clinical staff over decisions which affected them.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that patients receive medical and speciality reviews in a timely manner. Regulation 12 (2) (a) (b) (i)
- The trust must ensure all risks are assessed to patients using service, particularly the risks of developing pressure ulcers while waiting on trolleys for long periods in the ambulance corridor. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that the dignity of all patients using the service is always protected. This includes specifically the booking in process at the front desk and when speaking to the visual assessment clinician nurse, and for all patients cared for in the ambulance corridor. Regulation 10 (a)

Action the provider **SHOULD** take to improve

- The trust should ensure that there are enough consultants working in the department to keep patient safe, even in times of overcrowding. Regulation 12 (c)
- The trust should ensure that its nurse vacancies are fully recruited to in order to keep patients safe even in times of overcrowding. Regulation 12 (c)
- The trust should ensure that governance processes are sufficiently robust. Actions from action plans and other improvement initiatives should be verified to ensure they have been effectively implemented and where appropriate, change audits undertaken to demonstrate sufficient improvements have been made. Regulation 17(1)(2)(e)(f)
- The trust should consider improving emergency department consultant representation at board level.

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 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity

Regulation

Treatment of disease, disorder or injury

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