Worcestershire Acute Hospitals NHS Trust

Alexandra Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Urgent and emergency services	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at the Alexandra Hospital on 14 January 2019, in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

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

- There were delays in off-loading ambulances 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 crowded corridor at the time of the inspection.
- Triage times were not always in line with guidance. Some patients waited 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. The trust reviewed these patients and reported no harm had been experienced.
- The emergency decision unit did not have separate male and female areas.
- Not all emergency equipment was recorded as checked in line with trust policy or best practice.
- The department did not offer majors' treatment for sick children, but some parents brought children to this ED. There was only one paediatric trained nurse employed in the department. There were no child specific competency frameworks used to train adult nurses how to look after children. Nursing staff did not have paediatric competencies. There were some shifts without an advanced paediatric life support trained nurse, although there were always medical staff on duty who had advanced paediatric life support training.
- Whilst there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care at the time of the inspection, consultant cover in the department did not meet recommended guidelines. Some doctors told us they needed more doctors in order to keep the department safe when it was overcrowded.
- Patient privacy and dignity was not always protected due to overcrowding. Nurse handover was taken in the middle of the ward outside a patient cubicle. Handovers could be heard by other people in the department.
- 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.
- Specialty doctors were unable to respond to all patients in a timely manner.
- Some staff were frustrated by the recent changes to service delivery. This included the change of post code areas and the frequent ambulance diversions to the Alexandra Hospital from Worcestershire Royal hospital.

However:

- Staff cared for patients with compassion during the inspection. Staff were friendly, professional and caring at all times even when under extreme pressure due to overcrowding in the department. Staff tried to maintain patient privacy and dignity in times of overcrowding.
- Feedback from parents and relatives confirmed staff treated them well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment.
- Patients received a comprehensive assessment in line with clinical pathways and protocols. Risk assessments were completed accurately, and actions taken to address any concerns.

Summary of findings

- There were processes in place to escalate concerns regarding patients' safety/care or treatment. The trust had policies in place for responding when demand exceeded capacity in the ED. The service had introduced a tool for recognising patients at risk which promoted actions to be taken to prevent deterioration.
- All patient assessments we looked at included an accurate NEWS score, which had been recorded on admission and regularly thereafter.
- There were enough nursing staff with the right qualifications, skills, training and experience to keep adult 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.
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Clinical leaders were visible in the department.
- 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.
- Staff and managers across the service 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.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Reduce the number of ambulance handover delays.
- Ensure all patients receive timely initial clinical assessments.
- Ensure all patients are seen by emergency department doctors and speciality doctors when needed.
- Reduce the number of patients cared for in corridor areas.
- Consultant cover in the department must meet national guidelines.

In addition, the trust should:

- Fully implement the trust wide actions to reduce overcrowding in the department.
- Emergency equipment must be recorded as checked in line with trust policy.
- Consider joint nursing and medical handovers.
- Review that nursing handovers occur in an appropriate environment which allows privacy for patients and patient details.
- Monitor that there are nursing staff with children's nursing competencies on duty at all times.
- Review mixed sex breaches in the emergency decision unit to ensure separate areas are available to respect dignity and privacy.
- Monitor that medicines are provided from pharmacy and administered by staff in a timely manner.

Following this inspection, we considered enforcement action, however, we were not assured that conditions applied would benefit or improve the situation or manage the risks. The trust was therefore issued with a requirement notice.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection, the department was under adverse pressure 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. We did not inspect any other core service or wards at this hospital. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

Alexandra Hospital

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Detailed findings

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Background to Alexandra Hospital

The Alexandra Hospital is based in Redditch, Worcestershire, and is part of Worcestershire Acute Hospitals NHS Trust. The Trust was established in April 2000 and provides acute healthcare services to a population of around 580,000 in Worcestershire and the surrounding counties. The Trust runs two emergency departments, based at Worcester and Redditch, and a minor injuries unit based at Kidderminster Hospital and Treatment Centre, in Kidderminster town. Worcestershire Royal Hospital provides the trust's largest emergency department.

The figures below are for attendances combined between both Worcestershire Royal Hospital and Alexandra Hospital emergency departments.

Trust activity for the emergency departments from August 2017 to July 2018:

- 191,555 A&E attendances (+2% change compared to the same time 2016/17).
- 38,170 Children attendances (-4% change compared to the same time 2016/17).
- 48,376 ambulance attendances (+3% change compared to the same time 2016/17).
- 6% patients left without being seen (+6% change compared to the same time 2016/17).
- 11.6% reattendances within 7 days (+11.6% change compared to the same time 2016/17).

From April to December 2018 there were 40,047 attendances at Alexandra Hospital. From 22 December 2018 to 6 January 2019, the service saw between 135 and 167 patients per day.

We previously inspected the emergency department (ED) at Alexandra Hospital in March 2018. We rated it as requires improvement overall. Prior to that, inspections were completed in April and November 2017 to follow up concerns identified in a Section 29A Warning Notice and our comprehensive inspection in November 2017. Previously, the trust was issued two Section 29A Warning Notices under the Health and Social Care Act 2008 and were required to make significant improvements in the quality of care provided. Concerns with the ED were raised in both Warning Notices, which were issued in January and July 2017.

Our inspection team

The inspection team comprised of Phil Terry, Inspection Manager, one other CQC inspector, a registrar doctor specialist advisor in urgent and emergency care and an emergency department matron specialist advisor. The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	**Requires improvement** 

Information about the service

The emergency department (ED) at the Alexandra Hospital provides services 24-hours per day, seven days per week and serves the population of Redditch and surrounding areas. There are approximately 55,000 attendances each year. The number of children attending the ED has decreased from approximately 11,000 to around 7,000 (13% of all attendances) in the last year. This is due to the reconfiguration of paediatric services to another site at the trust. Ambulances no longer bring seriously ill or injured children to this department.

The ED consists of a minor treatment area with seating and five trolley cubicles, a major treatment area with 14 trolley cubicles, including three side rooms, and a resuscitation area with three bays. There is a five-bedded observation ward known as the emergency decision unit (EDU). There are two designated paediatric cubicles and a paediatric observation bay located opposite the nursing station. Areas designated for paediatrics are also used for adult patients when required. There was one triage room, one waiting area with a children's play room off, and one quiet relatives room. Additionally, there was a psychiatric interview room, and a clinical assessment room used for eye examinations and ear, nose and throat investigations.

During the inspection, we visited the ED and the EDU. We spoke with 18 staff including registered nurses, health care assistants, reception staff, medical staff, and managers. We spoke with thirteen patients and four relatives, and we reviewed 22 sets of patient records.

Summary of findings

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

- There were delays in off-loading ambulances 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 crowded corridor at the time of the inspection.
- Triage times were not always in line with guidance. Some patients waited 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. The trust reviewed these patients and reported no harm had been experienced.
- The emergency decision unit did not have separate male and female areas.
- Not all emergency equipment was recorded as checked in line with trust policy or best practice.
- The department did not offer majors treatment for sick children, but some parents brought children to this ED. There was only one paediatric trained nurse employed in the department. There were no child specific competency frameworks used to train adult nurses how to look after children.
- Whilst there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the

Urgent and emergency services

right care at the time of the inspection, consultant cover in the department did not meet recommended guidelines. Some doctors told us they needed more doctors in order to keep the department safe when it was overcrowded.

- Patient privacy and dignity was not always protected due to overcrowding. Nurse handover was taken in the middle of the ward outside a patient cubicle. Handovers could be heard by other people in the department.
- 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.
- Specialty doctors were unable to respond to all patients in a timely manner.
- Some staff were frustrated by the recent changes to service delivery. This included the change of post code areas and the frequent ambulance diversions to the Alexandra Hospital from Worcestershire Royal hospital.
- Nursing staff did not have paediatric competencies. There were some shifts without an advanced paediatric life support trained nurse, although there were always medical staff on duty who had advanced paediatric life support training.
- Some staff were frustrated by the recent changes to service delivery. This included the change of post code areas and the frequent ambulance diversions to the Alexandra Hospital from Worcestershire Royal hospital.

However:

- Staff cared for patients with compassion during the inspection. Staff were friendly, professional and caring at all times even when under extreme pressure due to overcrowding in the department. Staff tried to maintain patient privacy and dignity in times of overcrowding.
- Feedback from parents and relatives confirmed staff treated them well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment.
- Patients received a comprehensive assessment in line with clinical pathways and protocols. Risk assessments were completed accurately, and actions taken to address any concerns.
- There were processes in place to escalate concerns regarding patients' safety/care or treatment. The trust had policies in place for responding when demand exceeded capacity in the ED. The service had introduced a tool for recognising patients at risk which promoted actions to be taken to prevent deterioration.
- All patient assessments we looked at included an accurate NEWS score, which had been recorded on admission and regularly thereafter.
- There were enough nursing staff with the right qualifications, skills, training and experience to keep adult 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.
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Clinical leaders were visible in the department.
- 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.
- Staff and managers across the service 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.

Urgent and emergency services

Are urgent and emergency services safe?

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

- There were delays in off-loading ambulances 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 crowded corridor at the time of the inspection.
- Triage times were not always in line with guidance. Some patients waited 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. The trust reviewed these patients and reported no harm had been experienced.
- The emergency decision unit did not have separate male and female areas.
- Not all emergency equipment was recorded as checked in line with trust policy or best practice.
- The department did not offer majors treatment for sick children, but some parents brought children to this ED. There was only one paediatric trained nurse employed in the department. There were no child specific competency frameworks used to train adult nurses how to look after children.
- Whilst there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care at the time of the inspection, consultant cover in the department did not meet recommended guidelines. Some doctors told us they needed more doctors in order to keep the department safe when it was overcrowded.

However:

- Patients received a comprehensive assessment in line with clinical pathways and protocols. Risk assessments were completed accurately, and actions taken to address any concerns.
- There were processes in place to escalate concerns regarding patients' safety/care or treatment. The trust had policies in place for responding when demand exceeded capacity in the ED. The service had introduced a tool for recognising patients at risk which promoted actions to be taken to prevent deterioration.
- All patient assessments we looked at included an accurate NEWS score, which had been recorded on admission and regularly thereafter.
- There were enough nursing staff with the right qualifications, skills, training and experience to keep adult 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.

Environment and equipment

- **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 crowded corridor at the time of the inspection.**
- The size and layout of the emergency department (ED) was not always suitable for the number of patients using the service. During our inspection, we saw there was between three and four patients at all times being nursed on trolleys in the ED corridor. These patients were cared for by ED staff, who had been dedicated to look after the corridor.
- Patients in the corridor did not have access to a patient call bell and some could not easily call a nurse for assistance. One patient told us they had been unable to attract the attention of staff and were now desperate to use the bathroom. We highlighted this patient to the nurse in charge and assistance was provided immediately.
- Patients were treated on trolleys in the ED corridor where it was not always possible to ensure patients privacy and dignity needs were always protected. Patients requiring procedures which might expose them, for example an ECG, were moved to another area outside of the corridor and which was private.
- 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 in the department. Despite staffs' best attempts, confidential information could not always be protected.

- Patients on trolleys in the ED corridor experienced frequent movements from staff, other patients and equipment which invaded their allocated space. It was difficult to rest in this environment and it was not unusual that patient trollies would be knocked by the movements within the department.
- **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 ED corridor was full remained in the care of the ambulance service until they were handed over to ED staff inside the department. There was a joint statement for the 'management of patients in the corridor', which had been agreed between the ED and ambulance service. The agreement included a flow chart which indicated all patients would be visualised by ED staff within 15 minutes of arrival, reviewed by a clinician within 30 minutes and receive an 'executive' review after 60 minutes of waiting. We were told that after 60 minutes of delay, ambulances could leave, and the patient would become sole responsibility of the ED. We were told compliance to this agreement was audited, but the results were not available at the time of our inspection.
- There was a hospital ambulance liaison officer (HALO) employed to work in the department. However, they had been off work for some time and were not on duty during our inspection. HALO's assist with the patient flow in ED and work closely with ambulances operating in the region.
- Patients waiting under the care of an ambulance crew for one hour or more are called a black breach. From April to December 2018, there were 625 black breaches in this service. This was an increase of 421% on the same period the previous year, when there were 120. From 31 December 2018 to 10 January 2019, there were 93 black breaches recorded at the Alexandra Hospital. In January 2019, the average time for ambulances to handover their patients to ED was 33 minutes. This was worse than the previous month, December 2018, when it was 29 minutes. From April 2018 to January 2019, average ambulance handover times had increased steadily.
- Trust wide, more patients waited over one hour under the care of an ambulance crew than the England average. In October 2018, 12% of ambulances waited more than 60 minutes compared with the national average of 5%. From 24 December 2018 to 6 January 2019, 15% of all ambulance crews were delayed by more than an hour. During our inspection we did not see any black breaches at the Alexandra Hospital.
- From 30 December 2018 to 6 January 2019, 388 patients had been nursed in the corridor. This had come down from the previous week when the figure was 432. However, the total time patients spent in the corridor had increased from 488 hours to 502 hours in the same period.
- Trust data showed that between 26 December 2018 and 10 January 2019, daily there were:
  - between 132-150 attendances.
  - between 52 to 82 four-hour breaches.
  - between 48% to 64% Emergency Access Standard (EAS) performance.
  - between 0 -1 12-hour breaches.
  - between 1 and 16 > 60-minute ambulance breaches daily.
- Additional patients waited with ambulance staff in an additional corridor which was external to the ED. During our inspection, this corridor was mostly not used; however, there were occasions when we observed up to three ambulance crews waiting to admit patients to the department. Nursing staff told us this corridor was very often cold because the automatic doors, which led to the outside, opened frequently.
- Nursing staff told us the additional corridor often had up to four patients waiting with ambulance crews, and that more patients waited inside ambulances in the ambulance drop off bay. During our inspection, we did not see any patients waiting inside ambulances.
- The ED corridor was not sufficiently wide to accommodate all of the movement in the department when it was crowded. We observed ED staff, porters and ambulance crews juggling with patient trollies and wheelchairs. The lack of space was exacerbated when relatives waited with patients in the corridor.
- The ED corridor posed a risk to the rapid evacuation of patients in the event of a fire or other emergency. For example, there was insufficient space round each corridor trolley to assist patients if they required immediate resuscitation.

- The corridor was not equipped with call bells and patients requiring assistance had to shout out to staff. A member of staff was always in this corridor area we noted. We spoke to one patient who required urgent assistance to use a bathroom and told us they had been unable to get staffs' attention. We highlighted this to the nurse in charge and assistance was provided immediately.
- **The emergency decision unit did not have separate male and female areas.** The emergency decision unit (EDU) did not meet the requirement for single sex accommodation. It consisted of five beds separated by a partitioned wall to the side and open at the front. The EDU accommodated both male and female patients. There were two bathrooms in the department, however these were not dedicated single sex use. Patients using the service had to walk in front of bed spaces occupied by a member of the opposite sex.
- **Whilst the service sufficient quantities of suitable equipment which was easy to access and ready for use, not all emergency equipment was recorded as checked in line with trust policy or best practice.**
- Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys which were sealed with a tamper evident tag. However, the resuscitation trollies were not recorded as checked every day. The resuscitation trolley in cubicle seven had checks missed for three non-consecutive days in October 2018; the trolley in cubicle six had checks missed for a day in September and a day in October 2018; a trolley in the EDU had checks missed for one day in January 2019, plus a day each in September and October 2018. The paediatric resuscitation trolley in the resuscitation bay had been checked daily.
- Emergency equipment in the resuscitation bay was not checked daily. Checks were not recorded for four days in January 2019, and six days in December 2018. Senior nursing staff told us these checks were required every day.
- There were sufficient oxygen cylinders available, and these were stored appropriately in the department.
- Clinical and non-clinical staff were aware of the location of the emergency equipment. Its location and how to use it was included the in induction of all staff. There was sufficient equipment such as adult, infant and paediatric pulse oximeters, blood pressure machines, thermometers, oxygen and suction for the number of patients requiring these.
- We found a cleaning fluid bottle in the paediatric play area while an unsupervised child was in the room. This was highlighted to staff during the inspection and removed immediately. The service raised this as an incident and carried out an internal investigation in line with trust policy.

Assessing and responding to patient risk

- **Whilst risks to patients were assessed and their safety monitored and managed, not all patients received treatment in a timely manner due to overcrowding. The trust reviewed these patients and reported no harm had been experienced.**
- The department had a safe and working triage system which was aligned to a nationally recognised triage system. This categorised patients according to a risk rating of one to five. For example, level two was a threat to life which required immediate nurse assessment and to see a doctor within 15 minutes; and level four was a moderate risk, to see a nurse within one hour and a doctor within two hours. Triage nurses were able to stream patients to the out of hours GP service that was located next to the ED.
- **Triage times were not always in line with guidance. Some patients waited considerable time to be assessed due to overcrowding.** Standards set by the Royal College of Emergency Medicine state that an initial clinical assessment should take place within 15 minutes of a patient's arrival at hospital. Data provided by the trust showed that in the week from 30 December 2018 to 5 January 2019, showed this had been achieved for 81% of attendances at Alexandra Hospital. This had improved from the previous week, when 78% of patients had been triaged within 15 minutes of arrival.
- During our inspection, we tracked the triage times for 15 patients. Eight patients, (53%) had been triaged within 15 minutes of their arrival. Six patients waited less than five minutes, four patients waited more than 30 minutes and the longest wait was 73 minutes. The average time of arrival to triage was 18 minutes. This was longer than the national recommended time of 15 minutes.
- Patients arriving by ambulance were seen based first on their clinical need, and then in order of arrival. Patients

arriving by ambulance as a priority call (blue light) were taken immediately to the resuscitation room. Ambulances telephoned the ED in advance so that an appropriate team could be alerted and prepared for the arrival of the patient.

- There was a standard operating procedure for patients being looked after in the corridor. Staff were fully aware of this policy.
- **There were delays in some patients being assessed by ED doctors due to overcrowding in the ED.** Patients did not always receive treatment in a timely way. For example:
  - We saw that a diabetic patient, with high blood sugar and dehydration, had arrived in the department at 2:11 on 14 January 2019.They were not provided with intravenous fluids until 10:05 on 14 January and had a delay in receiving their required insulin treatment. We highlighted this case to a senior nurse during our inspection. We were told that the pharmacy had been too busy to provide the insulin, and that they would follow up this case. Following the inspection, the trust provided evidence that it had investigated this case and that no harm had been identified to the patient as a result of this delay. However, their investigation showed that there was a high probability of potential harm. Triage was carried out at 02:18. The patient's blood sugars were monitored throughout the night. A doctor saw the patient at 11:00. Whilst there was a delay in obtaining the medicine, the patient did not show clinical evidence of ketoacidosis. The patient was subsequently managed with normal insulin regime with no further deterioration in their blood sugars.
  - We saw another patient who arrived at 2:14 on 14 January 2019, and who did not receive antibiotic treatment until 8:50am, despite having a NEWS of six, and being considered as a possible sepsis patient. This case was highlighted to a senior nurse during our inspection. Following the inspection, the trust provided evidence that it had investigated this case and that no harm had been identified to the patient as a result of this delay. The patient presented symptoms were assessed to be respiratory in origin. The patient had three sets of hourly observations carried out from triage. All recordings resulted in a NEWS of four which did not trigger a sepsis screen requirement. Patient was assessed by a doctor at 08:37 and was prescribed antibiotics due to a diagnosis of pneumonia as opposed to sepsis.
- **There were processes in place to escalate concerns regarding patients' safety/care or treatment. The trust had policies in place for responding when demand exceeded capacity in the ED. The service had introduced a tool for recognising patients at risk which promoted actions to be taken to prevent deterioration.** Staff in the ED recognised the increased risks associated with patients remaining in the department for considerable lengths of time. In order to reduce the risk, they had introduced the Global Risk Assessment Tool (GRAT) which required nurses to assess and record whether each patient was in an appropriate clinical area, for example, and if they had experienced treatment delays or had prolonged immobilisation. If a risk was present, the GRAT indicated the action staff had to take. Actions included informing the nurse in change and where appropriate, a senior doctor. However, during our inspection, we did not see any GRAT charts in use.
- Reception staff logged walk-in patient's details, and had written guidance on clinical 'red flags', such as chest pain, traumatic injury or signs of a stroke. The guidance informed them when they had to escalate a patient immediately to nursing and medical staff. Reception staff were able to describe when they would escalate patients to clinicians.
- The status of the ED was determined by a safety matrix that used information on patient numbers and complexity, ambulance arrivals and staffing levels, to assess if the conditions promoted patient safety. The categories were normal, busy, critical and overwhelmed.
- Most staff had received training in managing emergencies appropriate to their role. For example, 89% of clinical staff had received a minimum of intermediate life support training and 87% of clinical staff had received paediatric intermediate life support training. A nursing sister told us training was available for staff but there were sometimes delays in getting staff booked onto courses. Advanced adult life support (ALS) and advanced paediatric life support (PILS) training was not mandatory for nurses in ED. ALS training had been

completed by 20% of nurses and PILS had been completed by 21% of nurses. We were told that all senior doctors working in ED had advanced life support training.

- All staff we spoke with knew how to raise the alarm and seek urgent help in an emergency.
- We raised our concerns that not all patients received timely assessment and treatment at times when the ED was overcrowded. The trust said there was a number of assessment tools, policies and audits relating to processes it had implemented when there was increased capacity and demand in the ED. These tools and processes had been implemented to provide the ability to prioritise timely treatment for those patients at greater risk of deterioration. These included:
  - 'Standard Operating Procedure for ED covering the (GRAT), which included:
    - GRAT for patients waiting more than 60 minutes for formal handover from ambulance crew.
    - GRAT for patients waiting more than six hours in the ED.
  - Recognising and responding to early signs of deterioration in hospital patients.
  - The 'Full Capacity Protocol' included the process for risk assessing patients that were boarded on wards'.
- **Patients received a comprehensive assessment in line with clinical pathways and protocols. Risk assessments were completed accurately, and actions taken to address any concerns.** Patients were assessed using a combined form which contained a medical admission and a nursing admission template. This included sections for clinical observations (national early warning score), Glasgow coma scale and details of past medical history, complaint history and a section for treatment plans. These were completed by the nurse and doctors attending the patient and clearly described the assessment process, treatment given and planned, and the outcome of any investigations.
- Patients using the service had access to specialist care teams. Notes we reviewed showed that patients had been referred to and were seen by appropriate peripatetic staff which included palliative care teams, alcohol liaison nurses, mental health teams and physiotherapists.
- We noted that patients in the resuscitation bay received a high standard of clinically appropriate care.
- **All patient assessments we looked at included an accurate NEWS score, which had been recorded on admission and regularly thereafter.** The national early warning score 2 (NEWS) and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'Acutely ill adults in hospital: recognising and responding to deterioration' (2007). We looked at 17 NEWS charts and saw clinical observations had been repeated in line with the previous score and escalated when scores were elevated. Compliance with recording and escalating NEWS was audited in the ED. Data provided by the service showed in December 2018 that the department was 99% compliant with recording a NEWS: 99% compliant with recording the correct NEWS and 100% compliant with escalation of NEWS.
- Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection. Staff had received training in sepsis and there was a sepsis lead for ED in the department. We saw patients in the department who had the sepsis pathway implemented, and that diagnostic and initial treatment had been completed within one hour of identification of sepsis. This was in line with the NICE guideline (NG51) 'Sepsis: recognition, diagnosis and early management'. However, we saw one patient who had not been commenced on the sepsis pathway in a timely manner, despite a clinical presentation which indicated sepsis was a possibility. This patient was highlighted to a senior nurse during our inspection.
- Nursing staff had access to mental health liaison services 24 hours a day, seven days a week. Staff knew how to make an urgent referral and we were told patients were seen promptly. The liaison team was staffed by the local mental health trust and was available from 8am to 10pm. Out of hours, staff contacted the mental health crisis team, to provide assessments. There was a specific risk assessment for patients who described mental health problems. The assessment helped staff to determine whether patients were high, moderate or low risk, which then ensured the patient was given an appropriate level of priority.
- Most nurses and doctors told us that trust policies and procedures were easy to find on the trust intranet. There was an emergency department handbook which contained clinical guidelines.

Medicines

- **Patients in the ED generally received their prescribed medications in a timely way.** Prescription charts we reviewed for patients in the main ED showed that when a medication had been prescribed, it had been given to the patient soon afterwards.
- **However, one patient prescription in EDU showed medication had not been administered on 10 occasions, over three days, due to stock not being available in the department.** The missed medication included a medicine to ease the symptoms of chronic obstructive pulmonary disease (five missed doses); a blood thinning medication (two missed doses); and blood pressure medication (two missed doses), plus a bone supplement. Nurses working in EDU told us patients mostly brought their own medications from home, however there were sometimes delays in obtaining drugs from pharmacy. We were told that the missing drugs had been ordered on the days of our inspection.

Nursing staffing

- **There were enough nursing staff with the right qualifications, skills, training and experience to keep adult patients safe from avoidable harm and to provide the right care.**
- The ED used a combination of the baseline emergency staffing tool and the National Institute of Health and Care Excellence (NICE) emergency department staffing recommendations, to ensure the department was staffed appropriately. This outlined how many registered nurses were needed to safely staff the department. The tools looked at the acuity of patients and how many were in the department at certain times of the day. As a result, the department had increased its staffing numbers to include a nurse specifically allocated to looking after patients in the corridor.
- During our inspection, the skill mix of staff was suitable for the needs of the ED and actual staff numbers on duty where the same as planned levels. Senior staff had oversight of the staffing within the department and told us they moved staff around to ensure all areas were safe and that surges in demand were managed.
- The nurse rota showed that most shifts were filled, and that the department was fully staffed. For example, from 7 to 13 January 2019, all shifts in the ED had been filled. This included using bank and agency nurses when necessary, to cover unexpected absences due to sickness, for example. The week commencing 14 January 2019, had a total of 10 outstanding shifts across the seven-day period. A nursing sister told us these shifts were put out to bank and agency and that they were hopeful they would be filled.
- The department had both bank staff and agency staff who were used regularly. An agency nurse we spoke to told us they had completed a local induction and were familiar with the department. Bank staff covered short notice absences and predicted increases in demand.
- There was a dedicated nurse allocated to looking after up to four patients in the ED corridor. This was staffed 24 hours a day and was provided as an extra member of staff to the ED.
- **The department did not offer majors' treatment for sick children, but some parents brought children to this ED. There was only one paediatric trained nurse employed in the department. There were no child specific competency frameworks used to train adult nurses how to look after children.** There was one duel registered, adult and child nurse working in the ED. This ED did not provide care and treatment for the sickest children and did not have its own children's ED. This was the only member of staff who was a qualified children's nurse. Adult nurses were not taught child specific competencies. There was a children's link nurse in the department who attended update training and shared this with other ED nurses. Medical staff told us they were supported by staff at Worcestershire Royal Hospital if they had any concerns regarding children, and that there was sometimes qualified child nurses available in the outpatient clinics if required.
- There was one child seeking treatment in the department during our inspection. The patient was triaged within 16 minutes and seen by a clinician in two hours and 35 minutes. Nursing staff told us children in the county were taken to the Worcestershire Royal Hospital by the ambulance service. However, parents brought some children to this ED despite the ED only offering minor treatment for children.
- Senior nurses in the department monitored the skill set of the nurse in charge of each shift. This was to ensure someone was always available with the required skills to manage the department. However, there were gaps on some days. This included 7 January 2019 and 11 to 13 January 2019, inclusive, when there was no nurse with

advanced paediatric life support skills on the early or the late shift. We were told there was always a member of the medical staff on duty who had advanced life support training for paediatrics.

- Nursing handovers included all nurses working in the department, except for the nurse looking after patients in the EDU. Medical staff held separate handovers to nursing staff. Nurses told us doctors communicated information about patients to the nurse in charge. When a doctor required a nurse to carry out a task, take blood or administer medication, for example, this was written in the patients notes, and left in a dedicated 'to do' tray at the nurse's station. Urgent tasks were verbally communicated to nurses.

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 provide the right care at the time of the inspection, consultant cover in the department did not meet recommended guidelines. Some doctors told us they needed more doctors in order to keep the department safe when it was overcrowded.**
- Consultants were in the department from 9am to 10pm weekdays, and from 9am to 7pm on weekends. This did not meet the Royal College of Emergency Medicine (RCEM) minimum standard of 16 hours consultant presence each day. On some weekdays, consultant cover ended at 8.30pm.
- There were five whole time equivalent consultants at the Alex ED; two of these were substantive posts, two were long-term trust contracted developmental consultant locums, and one was an hourly paid long-term locum. The department included the long-term contracted developmental consultant locums in their daytime consultant cover rota. However, the development consultants were supervised at all times by a substantive consultant and did not perform on-call duties. We were told the department planned to recruit two more consultants and that interviews were planned for February 2019.
- Outside consultant hours, the department was led by a doctor ST4 level or above. A consultant told us a second doctor was required at night due to recent changes in area post codes, which had resulted in increased attendances at this ED. We were told this was on the risk register.
- The department saw less than 16,000 children a year and therefore did not require a consultant with specialist training in paediatric emergency medicine. Consultants and registrars were trained in advanced paediatric life support.
- There were eight junior doctors on the rota and there was currently one vacancy. There was funding for nine middle grade doctors. Three of the middle grade doctors were trainees. We saw consultants working clinically in the department. They led the treatment of the sickest patients, gave advice to more junior doctors and we were told they ensured a structured clinical handover of each patient's treatment when shifts changed. We did not observe a medical handover.
- Junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and always accessible. Teaching was provided weekly to junior doctors. However, some doctors expressed concerns that at times of overcrowding, the ED did not feel safe.

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 therefore there is no rating. We found that:

- Staff cared for patients with compassion during the inspection. Staff were friendly, professional and caring at all times 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.

- Staff involved patients and those close to them in decisions about their care and treatment.

However;

- Patient privacy and dignity was not always protected due to overcrowding. Nurse handover was taken in the middle of the ward outside a patient cubicle. Handovers could be heard by other people in the department.

Compassionate care

- **Staff cared for patients with compassion at all times during the inspection.Staff were friendly, professional and caring, even when under extreme pressure due to overcrowding in the department.**
- We saw that all staff did their best to ensure patients were comfortable. We saw that all staff, including administrative staff attended patients, and answered any calls for help. Additional blankets, pillows and refreshments were offered to try and enhance comfort.
- It was impossible for staff to maintain the privacy and dignity needs of the patients cared for in the corridor due to overcrowding. However, staff used screens to provide privacy for treatments if a cubicle was not available. Nursing staff were attentive to patient's needs.
- Due to the proximity of other patients, it was not always possible for staff to have private conversations with patients without being overheard. However, we saw that staff spoke quietly, and took relatives to the side to ensure that confidential information was not shared.
- Staff were friendly, professional and caring at all times. We saw that staff interacted positively with patients and their relatives. All attempts were made to ensure that the patients' experience was a positive one. Staff remained good humoured, engaged in conversations and promoted discussions with patients and relatives, throughout the inspection.
- Nurse handover was taken in the middle of the ward outside a patient cubicle. Handovers could be heard by other people in the department. We observed a nurse handover where a relative asked that the bedcurtains be closed as there were so many people standing close to a patient's bed space leaving them with no privacy.
- **Feedback from parents and relatives confirmed staff treated them well and with kindness.**Patients said they were very happy with how happy they were treated by the staff. They said staff were "always very caring", and "were very friendly". Patients were generally positive about the care they received from staff in ED. Some patients had health concerns which meant they attended the department frequently. These patients and their relatives expressed sympathy with how hard the nursing team worked and told us it was always busy. Patients told us that the nurses were kind and caring.
- **Patient privacy and dignity was not always protected due to overcrowding. Nurse handover was taken in the middle of the ward outside a patient cubicle. Handovers could be heard by other people in the department.**We observed a nurse handover where a relative asked that the bedcurtains be closed as there were so many people standing close to patients' bed-space leaving them with no privacy.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patients told us they generally felt well informed about their care and treatment, although a few referred to delays in updates. The service had developed a patient information leaflet, which gave details of what to expect when attending the department. We saw that this was shared with patients and information explained if necessary.

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

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

- Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.
- Specialty doctors were unable to respond to all patients in a timely manner.

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 in place to manage the flow of patients through the emergency department (ED) and to

discharge patients or to admit them to the hospital. The operations control room and clinical site team saw on the IT system 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.

- ED escalation levels were determined by the regional health economy Escalation Management System (EMS). EMS levels were graded one to four. EMS one is normal working, and three, is the department is under severe pressure. In the week commencing 30 December 2018, the department reported three days when it was EMS three or above.
- The status of the ED was reported to the bed management team via an electronic system. Bed management meetings took place four times per day and were attended by senior staff from across the hospital, including ED. We did not attend a bed meeting but we were told staff worked together to review capacity and identify ways to improve flow and minimise the impact on patients.
- During our inspection, a trust capacity meeting resulted in ambulances being diverted from Worcestershire Royal Hospital (WRH) to the Alexandra Hospital. The diversion agreement was for three hours, and for a maximum of two ambulances per hour to be redirected. Whilst this action improved patient flow at WRH, it increased delays for patients using the ED at Alexandra Hospital.

Activity

- NHS Trusts are required to monitor and report nationally the percentage of patients who attend ED and get seen, discharged or admitted within four hours of arrival. This is known as the Emergency Access Standard (EAS). The NHS standard requires 95% of patients to spend less than four hours in ED.
- Trust data showed that Alexandra Hospital performance from 31 December 2018 to 10 January 2019 was:
  - 31 Dec 2018:Attendances -157;4-hour breaches -74;EAS (%)-53;12-hour breaches -1;>60-minute ambulance delays -16.
  - 3 Jan 2019: Attendances -152; 4-hour breaches -67;EAS (%)-56; 12-hour breaches - 0; >60-minute ambulance delays -9.
  - 7 Jan 2019: Attendances -143; 4-hour breaches -76;EAS (%)-48; 12-hour breaches -1; >60-minute ambulance delays -9.
  - 10 Jan 2019: Attendances -150; 4-hour breaches -63; EAS (%) -59;12-hour breaches -0; >60-minute ambulance delays -4.
- In the week ending 6 January 2019, the EAS at Alexandra Hospital was 56%. This was worse than in the previous week when it was 62%. From April 2018 to 6 January 2019, on average 72% of patients spent less than four hours in ED.
- Data for October 2018 showed that 61.2% of patients spent less than four hours in the type one majors' departments in the trust. This was a deterioration from the previous year (81.8%) and much worse than the national comparison of 83.2%.
- Similarly, data showed that 75% of all patients spent less than four hours in any area of the emergency departments in the trust. This was a deterioration from the previous year (81.8%) and much worse than the national comparison of 87.4%. However, data showed that the service performed similar (0.9) to the national comparison (1.0) for the total time all patients spent in the department.
- Once a decision to admit a patient had been made, there were delays in moving patients to a hospital bed. The trust set a target of moving patients within two hours, however, from 30 December 2018, to 6 January 2019, only 50% of patients had been moved to a hospital bed within this time. The average time patients waited to be admitted to a bed was three hours and 24 minutes.
- Trustwide, in October 2018, 45% of admissions waited between four and 12 hours in ED from a decision to admit. This was worse than national average of 12%. In October 2018, 25 patients spent more than 12 hours waiting in ED from the decision to admit to admission. This was a deterioration from the previous year and was worse than the national average.
- Clinical staff and patients told us there were often periods of overcrowding in the department when all trolleys and bays were occupied. This meant ambulance crews could not offload their patients into an appropriate space inside the ED, and patients had delays in accessing care. During these periods, the

corridor was used as extra capacity, and ambulance crews offloaded up to four extra patients. However, once patients had filled the four corridor spaces, further patients were unable to access the department and had to wait with ambulance staff outside of the ED.

- The Alexandra Hospital had a frailty assessment unit, which was open Monday to Friday from 8am to 8.30pm. The frailty unit allowed elderly and frail patients to bypass the ED and therefore reduce some ED attendances which otherwise would have increased demand in the department. We did not inspect this service.
- There was on onsite GP service which was ran separately from the hospital. However, we were told the service actively assisted wherever possible, by seeing ED walk in patients with minor injuries, or who were more suitable for GP care, rather than emergency care.
- **Specialty doctors were unable to respond to all patients in a timely manner.** Speciality doctors were unable to respond to all patients in a timely manner. There were long delays to see specialist doctors which resulted in patients staying in the department longer than necessary. This impacted on patient flow.
- Some patients had to wait too long to see a speciality doctor after a referral had been made by ED staff. Some patients waited too long before a referral was made. One of the reasons patients spent a long time in ED was because they had been referred to a specialty doctor but one was not immediately available. For example, we saw a patient had arrived at 13:53 and was triaged at 14:46: they were referred to the medical team at 15:05 and seen at 19:00. Further specialist delays included a patient who arrived at 11:55 and was seen at 17:41; a patient arrived at 11:48 and was seen by a speciality doctor at 8:05am; and a patient who arrived at 13:58 and who was seen at 19:00.
- Data provided by the service showed that in the week ending 6 January 2019, 36% of patients waited more than two hours before a referral was made to a speciality team. Once a referral had been made, 59% of patients waited over an hour for a specialist to see them. The trust had introduced internal professional standards which included specialist doctors seeing 80% of patients within one hour of referral. For the week ending 6 January 2019, 41% of patients were seen by a specialist within one hour of referral. This was lower than the previous week, when 61% of patients were seen within an hour.
- On the evening of our inspection, we were told that the hospital had 11 empty beds. Despite this, the ED remained overcrowded and at 20:30, when we left the department there were four patients in the ED corridor, four patients with ambulance staff outside the ED corridor, and further ambulances arriving outside of the department.

Are urgent and emergency services well-led?

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

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Clinical leaders were visible in the department.
- 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.
- The service had a systematic approach to continually monitor the quality of its services. The service monitored activity and performance and used data to identify areas for improvement.
- Staff and managers across the service 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.

However:

- Some staff were frustrated by the recent changes to service delivery. This included the change of post code areas and the frequent ambulance diversions to the Alexandra Hospital from Worcestershire Royal hospital.

Leadership

- **The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Clinical leaders were**

visible in the department. Leadership in medical and nursing staff was clear, positive and collaborative. We saw that they interacted positively with all staff, ensuring that the department was well-managed. It was clear from staff interactions that they had a belief in the leadership of the team. Staff sought their help and opinion when they needed it. Leadership for each clinical area was clearly displayed. Staff were allocated to specific roles within the department, and had armbands denoting what they were responsible for. The nurse in charge of the shift, was kept well informed and had oversight of all activity. Senior staff in the department felt very well supported by the trust's executive team and that their concerns were listed to and acted upon.

- Nursing and medical staff held separate handovers and doctors outside of the main resuscitation bay communicated mainly with the nurse in charge of the shift.

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.**
- 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. The beds were planned to open shortly after our inspection and were part of a hospital wide reconfiguration. The reconfiguration of services included moving patients that were being cared for in surge areas and this would enable surge areas to function as normal. The trust had worked with the local Healthwatch regarding care for patients in corridor areas in the department.
- 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). There were also plans to redirect patients from within two postcodes tin the Droitwich area to the Alexandra Hospital. This change was planned for completion at the end of January 2019.
- Senior staff reported effective and positive support from NHS Improvement who had been supported the service with a range of measures to reduce overcrowding in the department.

Governance, risk management and quality measurement

- **The service had a systematic approach to continually monitor the quality of its services. The service monitored activity and performance and used data to identify areas for improvement.**
- Data relating to performance was clearly displayed in the unit. 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
- The service maintained a dashboard of activity which was discussed as part of team and management meetings. Audits of risk assessment in the department were carried out and used to drive improvements.

Culture within the service

- **Staff and managers across the service promoted a positive culture that supported and valued one and other. However, some staff were frustrated by the recent changes to service delivery. This included the change of post code areas and the frequent ambulance diversions to the Alexandra Hospital from Worcestershire Royal hospital.**
- Nurses and doctors said they gave the best care they could to all patients attending the ED However, they told us that the department was sometimes overwhelmed with patients and that there was not always enough staff to carry out all of the required tasks in a timely manner. Doctors told us they needed more doctors in the department to run a safe and effective service.
- Nurses told us they were not always consulted about ambulance diversions from Worcestershire Royal Hospital ED to the Alexandra Hospital ED, and told us they were often overwhelmed themselves to accommodate extra patients. Staff told us they felt the ambulance diversions were sometimes unfair.
- Nurses and doctors discussed the recent change in postcodes, and how this had affected and increased their workload. Some staff said they were not designed to cope with the extra capacity now required.

Urgent and emergency services

- Receptionists said there was not always two receptionists on duty in the evenings, which was a pressure.
- Nursing and doctors all spoke highly of the clinical leads in their department.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Areas the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the hospital MUST take to improve to:

- 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 that consultant cover in the department meets national guidelines. Regulation 12 (c)

Action the hospital SHOULD take to improve

- The trust should fully implement the trust wide actions to reduce overcrowding in the department. 12 (2) (a) (b)
- The trust should ensure that emergency equipment is recorded as checked in line with trust policy. Regulation 12 (e)
- The trust should ensure that handovers are completed ensuring patient privacy Regulation 10 (2)
- Monitor that there are nursing staff with children's nursing competencies on duty at all times. Regulation 18 (1)
- Review mixed sex breaches in the emergency decision unit to ensure separate areas are available to respect dignity and privacy. Regulation 10 (1) (2) (a)
- Monitor that medicines are provided from pharmacy and administered by staff in a timely manner. Regulation 12 (2) (f)

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **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 specialty reviews in a timely manner.** **The trust must ensure that consultant cover in the department at the Alexandra hospital meets national guidelines.**