North West Anglia NHS Foundation Trust

Peterborough City Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Peterborough City Hospital

Inspected but not rated

North West Anglia NHS Foundation Trust provides acute hospital services across three sites. At the time of our inspection, urgent and emergency care services were being provided across two sites from Peterborough City Hospital and Hinchingbrooke Hospital. The trust employs approximately 7,073 members of staff and is supported by approximately 452 volunteers.

We undertook an unannounced focused inspection of Peterborough City Hospital urgent and emergency care services and medical care services (including older people's care) on 28 February. We also had an additional focus on the urgent and emergency care pathways across Cambridgeshire and Peterborough and carried out a number of inspections of services across a few weeks. This was to assess how patient risks were being managed across the health and care services during increased and extreme capacity pressures.

As this was a focused inspection at North West Anglia NHS Foundation Trust, we only inspected parts of our five key questions. For both core services, we inspected parts of safe, responsive, caring and well led. We included parts of effective in medical care. We did not inspect effective in urgent and emergency care at this inspection but would have reported any areas of concern.

The emergency department at Peterborough City Hospital was previously rated as requires improvement overall with safe, responsive and well led being rated as requires improvement and effective and caring being rated as good. Medical care was previously rated as good overall with all key questions rated as good.

For this inspection, we considered information and data about performance for the emergency department and medical care. This inspection was partly undertaken due to the concerns this raised over how the trust was responding to patient need and risk in the emergency department and the wider trust in times of high demand and pressure on capacity. We were concerned with waiting times for patients, delays in their onward care, treatment and delayed discharges, as well as delayed and lengthy turnaround times for ambulance crews.

We looked at the experience of patients using urgent and emergency care and medical care services in Peterborough City Hospital. This included the emergency department, medical wards and areas where patients in that pathway were cared for while waiting for treatment or admission. We visited services and departments that patients may encounter or use during their stay. We also went to medical wards where patients from the emergency department were admitted for further care. This was to determine how the flow of patients who started their care and treatment in the emergency department and those cared for on medical wards, was managed by the wider hospital.

System wide summary

A summary of CQC findings on urgent and emergency care services in Cambridgeshire and Peterborough.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Cambridgeshire and Peterborough below:

Our findings

Cambridgeshire and Peterborough

Provision of urgent and emergency care in Cambridgeshire and Peterborough was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, urgent care, acute, mental health, ambulance services and in care homes and domiciliary care agencies (social care). Staff had worked very hard under sustained pressure across health and social care services. Staff reported feeling tired and frustrated due to the sustained pressure and the impact this had on their wellbeing and on the delivery of training.

We identified a need for more capacity in primary care to meet people's needs in Cambridgeshire and Peterborough. We found some concerns in relation to access for patients trying to see or speak to a GP; however, other services proactively reviewed patients' attendance at emergency departments and took action to reduce avoidable attendances and improve access to appointments.

We visited a primary care unit run by an acute trust; whilst this was working well, we were told it was addressing an issue in access to primary care and was a short-term solution. We were told of a GP liaison service which enabled GPs and Consultants to work together to discuss individual patient needs. This service had successfully supported a significant number of people to stay at home or to access an alternative pathway and avoid going to an Emergency Department.

Access to NHS111 services for people in Cambridgeshire and Peterborough was generally in line with or better than elsewhere in England. Performance was closely monitored and there were plans in place to address staff shortages, particularly for health advisors, and there was a successful on-going recruitment campaign.

System partners in Cambridgeshire and Peterborough had been part of a collaborative project to launch a Virtual Waiting Room within the Cambridge and Peterborough region. The initiative aimed to help patients who call NHS 111 receive the care they need while alleviating the pressure on Emergency Departments (EDs).

Staff working in ambulance services reported a significant volume of calls which were inappropriate for a 999 response and could have been dealt with in primary care or urgent care services. Staff also reported a high number of elderly people seeking support through emergency services because they felt their care packages were insufficient and did not meet their needs.

Ambulance crews also highlighted their frustrations with the variation in pathways at different hospitals across Cambridgeshire and Peterborough and that ambulance crews were not prioritised for accessing alternative pathways. By streamlining pathways and handover arrangements, ambulance crews felt they could be more efficient.

For many complex reasons, including ambulance handover delays and staffing shortages, there were not enough crewed ambulances to respond to 999 calls within national targets. This posed a risk to people in the community waiting for a 999 response.

Staffing shortages in some Emergency Departments impacted on the delivery of safe and effective care. Staff were not all up to date with mandatory training and did not always assess risks appropriately.

Our findings

We visited a mental health service and found it met the needs of people who presented in the Emergency Department or transferred between acute and mental health services. However, staff within Emergency Departments reported problems in accessing mental health services and were not able to make referrals 24 hours, seven days a week. This impacted on the ability to provide appropriate care and treatment and moving patients to the appropriate service.

Whilst we found some examples of collaborative working focused on developing system wide resilience, we found Emergency Departments remained under significant pressure. Patients experienced significant waiting times in these departments and staff reported the challenges of caring for patients within the department for such long periods of time. Some staff felt too much risk was accepted and held within emergency departments and didn't always feel supported by system leaders.

Same Day Emergency Care pathways aimed to relieve the pressure from Emergency departments. However, these services also experienced staff shortages, and some were only available during set times. Opportunities were lost to use admission avoidance pathways for the frail and elderly and increasing the risk of patient harm such as falls and skin pressure damage'

Delays in discharge for patients in hospital were significant and impacted on their health and wellbeing. Staffing issues were also impacting on the social care provision in Cambridgeshire and Peterborough; although there were beds available in care homes, there was not always enough staff to enable admissions. The staffing issues were also present in domiciliary care agencies which reduced the availability of care at home.

Staff working across health and social care reported poor discharge processes. Staff working in care homes and domiciliary care services reported that patients were often discharged late at night and with insufficient information to ensure a safe transfer of care.

Staff working in these services also reported significant delays in ambulance responses, however they gave very positive feedback in relation to welfare calls received by GPs or 111 and 999 call handlers.

We found a lack of knowledge across social care services in relation to managing deteriorating patients. By increasing staff awareness, services may be able to meet people's needs without needing to request emergency services.

We observed some local and system escalation meetings and found there was limited, if any action taken in response to issues and risks escalated.

Summary of North West Anglia NHS Foundation Trust – Peterborough City Hospital

We found:

- The services provided mandatory training in key skills in relation to patient risk but not everyone had completed it.
- The design, maintenance and use of facilities and premises in the emergency department did not always keep people safe. Staff did not complete risk assessments for each patient comprehensively to remove or minimise risks or update the assessments. Staff did not always keep detailed records of patient care and treatment. The emergency department did not have systems and processes in place to safely prescribe, administer, record and store medicines.
- Within the emergency department, staff were not always discreet or attentive when caring for patients.

Our findings

- People could not always access the emergency care service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Staff described a culture of acceptance given the capacity and lack of movement of patients through and out of the hospital. This led to extended patient waits and patients staying for longer than necessary in the emergency and urgent care environment.
- Within medical care, shortages of staff meant the service did not always have enough medical, nursing and support staff to keep patients safe from the risk of avoidable harm and to provide the right care and treatment in a timely way. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift.
- Although people could access the medical care services when they needed it, they did not always receive the right care promptly due to pressures on bed capacity. Arrangements to admit, treat and discharge patients were impacted due to significant numbers of patients that no longer met the criteria to reside in the hospital but were waiting for access to onward care packages. Patients were being moved, sometimes at night, in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment.

However:

- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Within the emergency care service there was enough nursing, medical staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix. The services managed infection risk well. Staff used personal protective equipment and control measures to protect patients, themselves and others from infection. Equipment and the environment were visibly clean.
- Within medical care, doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Key services were available seven days a week to support timely patient care.
- Within medical care, staff treated patients with compassion and kindness, they respected their privacy and dignity, and took account of their individual needs. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- Care was planned and provided in a way that met the needs of local people and the communities served. The services also worked with others in the wider system and local organisations to plan care.
- Leaders had the skills and abilities to run the services. Services had a vision for what they wanted to achieve and a strategy to turn it into action. Leaders operated effective governance processes throughout the service.

How we carried out the inspection

During the inspection we observed care, spoke with 37 members of staff and carried off site interviews with the senior leadership team. We spoke with 12 patients and/or their carers. We observed care provided; attended site meetings, reviewed relevant policies and documents and reviewed 22 sets of patient records.

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

Medical care (including older people's care)

Inspected but not rated

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. The trust had effective systems to ensure standards of hygiene and cleanliness were maintained. Staff monitored standards of cleanliness regularly and results were used to improve infection prevention and control (IPC) practices where needed. Staff displayed cleaning and environmental audit compliance data on a notice board that was visible to staff, patients and visitors.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment regularly and labelled it with the date of cleaning. Cleaning staff completed cleaning schedules, which were up to date and showed that areas had been cleaned regularly. Privacy curtains around beds were disposable and those seen were visibly clean. Staff had recorded the date these were put up.

Staff followed infection control principles including the use of personal protective equipment (PPE), such as masks, disposable gloves and aprons. PPE was readily available in all clinical areas. Staff adhered to 'bare below the elbows' principles to enable effective hand washing and reduce the risk of spreading infections. Hand sanitising units and handwashing facilities were available in all areas and handwashing prompts were visible for staff, patients and the public.

The trust had designated wards for patients with COVID-19 symptoms and those who were known to be COVID-19 positive. Staff knew which wards were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed with COVID-19 in accordance with trust policy. There were clear signs related to social distancing in waiting areas, such as ambulatory care.

The trust had rapid testing available for COVID-19. Staff screened patients for COVID-19 throughout their admission on set days and if they presented with signs and symptoms.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment was not always adapted to keep people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. Staff had easy access to equipment used in an emergency, such as resuscitation trolleys, which were available in each area we visited. Nursing staff kept records of checks of equipment on the trolley and whether tamper proof tags for the trolley drawers were undisturbed. Records showed staff completed these checks every day between 1 February 2022 and 28 February 2022.

Piped oxygen was available at each bed space, as well as emergency call bells. In June 2021 the National Patient Safety Agency (NPSA) issued an alert to all NHS trusts asking that the risk associated with inadvertently attaching patients to piped medical air flowmeters be eliminated. Bed spaces also had an air flow outlet available and we saw air flow meters continued to be attached to these in one ward. This increased the risk that the air flow meters could be inadvertently used.

We reviewed a copy of the trusts' action plan in relation to the alert and noted actions were still ongoing regarding the requisition of nebulisers, before being able to remove and discard all medical air flowmeters. Following our inspection, managers followed up with ward staff where air flowmeters remained in use to ensure they took the appropriate action to remove connections when the flowmeters were no longer in use. However, they were still not in a position to remove all air flowmeters from use.

Patients could reach call bells and staff responded quickly when called. Patients had call bells within reach, as well as other equipment, such as walking aids. Staff responded to call bells in a timely manner in each of the areas we inspected, and most patients told us they did not have to wait long for their bells to be answered. However, one patient out of the seven we spoke with said this could take up to 10 minutes.

The design of the environment followed national guidance. All wards were easily accessed and signposted from the main entrance. All wards we visited were arranged to ensure separate male and female bays, with separate toilet and washing facilities allocated to each bay.

Staff had enough suitable equipment to help them to safely care for patients. We looked at eight electrical appliances and pieces of equipment, which had been tested and serviced to ensure they were safe to use. Staff were aware when equipment was due to be serviced and took appropriate action to report any equipment not working correctly.

Staff disposed of clinical waste safely. Staff handled waste products appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly, in line with national guidance. Staff complied with arrangements for control of substances hazardous to health (COSHH), which were stored securely in locked cupboards.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the national early warning score 2 (NEWS2) point system tool, which is a standardised approach to detecting deteriorating patients. NEWS2 scores provided a prompt to staff entering the data to review whether the patient was unwell and/or deteriorating and required a medical review. The electronic system also alerted medical staff and, if appropriate, the critical care outreach team.

Medical care (including older people's care)

Staff knew about and dealt with any specific risk issues. They knew how to deal with any specific risk issues and there was a pathway for the management of sepsis. Sepsis is a potentially life-threatening illness when the body's response to infection injures its own tissues and organs. Early recognition and prompt treatment have been shown to significantly improve patient outcomes.

The trust had an acute oncology service in line with the recommendations of the National Chemotherapy Advisory Group report.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Medical staff completed an initial assessment for patients, which included their presenting problem, medical history and a physical assessment. Risk assessments were completed for patients and risk management plans were developed in line with national guidance. We reviewed seven sets of patient records and found these were legible and risks were monitored regularly.

Nursing staff completed further assessments for risks associated with venous thromboembolism, falls, nutrition and the development of pressure ulcers. These were documented in patient records and included actions to reduce any identified risks. The trust used specific tools to complete these assessments, such as the malnutrition universal screening tool to identify patients who were underweight, overweight or at risk of complications from these.

Data provided by the trust showed staff met the trust required 95% completion of venous thromboembolism (VTE) risk assessments. We saw that VTE assessments had been completed during our visit.

Ward staff completed intentional care rounding checks at least every two hours on all patients to document that care and comfort needs were met. Records showed that these checks had been completed and recorded.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff knew how to contact mental health liaison if they needed to refer a patient for specialist advice. A staff member commented they were able to access acute mental health beds and felt they had good 24 hour support in this area.

Staff shared key information to keep patients safe when handing over their care to others. We saw that safety briefings occurred in all areas at least once a day, which included discussion around staffing levels and the staff skill mix available. All grades of medical and nursing staff took part in ward and whiteboard handovers where key information was shared at different times throughout the day. This information included patient's wellbeing, their ongoing clinical needs, discharge planning and any additional key information appropriate to their care.

Staffing

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience, although they kept patients safe and provided the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, although this did not always prevent incidents from occurring.

Medical care (including older people's care)

The service did not have enough nursing and support staff to keep patients safe when we visited. Due to national shortages of nursing and support staff and staff absence the service did not always have enough nursing and support staff. Staffing pressures were made worse by the pressures of the COVID-19 pandemic. Staff reported being consistently overstretched and working with fewer staff than was required, and said they frequently worked at 70% of this figure. Managers reviewed staffing numbers on each ward three times a day, with escalation and mitigation processes in place.

Staff told us this often meant they worked additional hours and there was increased stress amongst staff, which impacted on their morale. Three staff told us they were not always able to provide required therapy or support to patients because of staff shortages. Information the trust provided stated there had been an increase in patients becoming ready for discharge while still awaiting formal support. A staff member in one unit told us they, “Don’t remember the last time [we] had all staff.” They told us there had only been three nursing staff, instead of the required eight the previous week, and we saw that was the case again during our visit.

The number of nurses and healthcare assistants did not always match the planned numbers. The trust provided data about nursing staff rates over the last 12 months and said their overall target vacancy rate was 5%. Of the 13 wards and units (with the exception of the medical assessment, short stay and ambulatory care units) that made up the medicine division, only two were fully staffed. Four wards had more than a 10% vacancy rate and one ward had nearly 24% staff vacancy. However, it was recognised nationally there was an increase in absence across the health and care sector, particularly due to short term sickness.

Three wards had more than the trust target for staff turnover of 10%, with one of these wards being almost three times that. Similarly, many wards did not meet the trust target of 4% for sickness levels.

Wards we visited displayed their daily staffing levels for registered nurses and healthcare assistants on both day and night shifts. However, for one ward this information was three weeks out of date.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Staff told us they assessed numbers of staffing required to be able to safely provide care to patients. Managers had daily meetings to identify any areas where staffing shortfalls occurred, and managers delegated staff accordingly. However, this meant managers often moved staff from fully staffed wards, to reduce risks of shortages in other areas.

The ward manager could adjust staffing levels daily according to the needs of patients. The trust had an escalation and mitigation process for staffing levels. Information provided by the trust however, showed increasing numbers of patients had falls on three wards in particular. This resulted in serious injury to 11 patients since April 2021, seven of which occurred in the six months prior to our inspection. The number of falls for all but two units in medicine had seen an increase in the number of patients falling.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients although they kept patients safe and provided the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not have enough medical staff to keep patients safe. Medical staff reported being consistently overstretched and working with fewer staff than was required. Staff told us they were frequently moved around to cover

different areas, which may have resulted in a lack of continuity of care for patients. This happened to both consultants and junior medical staff. One ward we visited only had one consultant, which meant not all patients had been seen by midday and so decisions about required tests and discharges were delayed. The ward's establishment numbers were for two consultants. Only one doctor we spoke with told us medical staffing in their ward had improved recently.

Local leaders reviewed staffing numbers on each ward each day, with escalation and mitigation processes in place.

The number of medical staff did not match the planned number. The trust provided data about medical staff rates over the last 12 months and said their overall target vacancy rate was 5%. Of the eight medical specialties the trust provided information about, only one was fully staffed. Two specialties had vacancy rates of nearly half their expected number of staff and one specialty had a 100% vacancy rate. This equated to an overall 14% and 21.8% medical vacancy rate across medicine, there were almost 30 whole time equivalent vacancies against the establishment number of nearly 156.

Managers could access locums when they needed additional medical staff. Information provided by the trust showed they used locum and bank medical staff in addition to their own permanent staff. However, the number used did not cover the number of medical staff that were not always available to meet the required numbers. Information provided by the trust shows on 12 days in February, including the day of our visit, there were not enough locum and bank staff to cover the existing medical staff vacancies.

The service always had a consultant on call during evenings and weekends. Staff confirmed consultant medical staff were available during evenings and weekends.

Is the service effective?

Inspected but not rated

We inspected but did not rate this service.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Information about the outcomes of patients care and treatment was routinely collected and monitored. Ward managers displayed quality and safety information including patient safety results, complaints and friends and family test results to inform patients and visitors of their performance.

The service participated in relevant national clinical audits, which included national audit of dementia, national heart failure audit, national lung cancer audit and the national asthma and chronic obstructive pulmonary disease (COPD) audit. Managers took appropriate action to monitor and review the quality of the service and to effectively plan for the improvements required.

Managers shared and made sure staff understood information from the audits. The division had a planned approach to clinical audits and a programme of audits was in place. Management and governance meeting minutes showed that completion was monitored and outstanding items or issues were discussed. Matron's dashboards were completed each month and displayed in prominent areas of each ward. These provided a month on month indication of how wards were managing in relation to areas such as falls and pressure ulcers.

Managers used information from the audits to improve care and treatment. We spoke with the ward manager on one ward that had seen an increase in the number of patients falling. The manager told us results of the dashboard were discussed during staff meetings, which gave all staff the opportunity to consider how to improve patients' experience.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care, although these were not always as effective as they could be. Staff completed board rounds daily, which were attended by consultants, junior doctors, the ward manager and nurses, However, allied health professionals, such as physiotherapists, were not always able to attend these rounds. We saw that both medical and nursing staff provided feedback about patients during these rounds. This provided opportunities to discuss patients' health and care needs but meant there was sometimes a delay in all staff groups being made aware of decisions.

Staff referred patients for mental health assessments when they showed signs of mental ill health and/or depression. Staff told us they were aware of the mental health liaison teams and how they would refer patients to the service.

Patients had their care pathway reviewed by relevant consultants. Medical staff told us they made referrals to other specialities via the trust's electronic referral systems and these were overseen by each patient's consultant. Patients were then seen by specialist nurses or consultants, who advised on appropriate care pathways. However, there were sometimes difficulties accessing consultants from other specialty services for patients in the medical admissions unit, which meant patients' stay in hospital could be lengthened.

Seven-day services

Key services were available seven days a week, however this did not always support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Both nursing and medical staff told us consultants were available seven days a week and on the medical assessment and short stay units, patients were seen on a daily basis. Other staff said consultants on some wards did not see all patients at weekends, although they were available if a patient's condition deteriorated.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Support was available 24 hours a day, seven days a week, although this could not be guaranteed for diagnostic tests. Staff on one ward told us there was a shortage of therapy staff. This limited their ability to take part in board rounds, which impacted on discharge arrangements. In another area staff told us diagnostic testing was prioritised for some patients at weekends and less easily available for non-urgent requests.

Medical care (including older people's care)

Is the service caring?

Inspected but not rated

We inspected but did not rate this service.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff interacting with patients in a positive and personalised way. Staff attitude was positive, and the atmosphere was warm and welcoming. Patients told us staff treated them well and with kindness, with one patient saying, “Staff are very nice here.” Another patient said, “The staff here are pretty good, they’re polite.” A third patient told us how staff had taken time to find out how the patient’s spouse was, as they were also a patient in the hospital.

Staff followed policy to keep patient care and treatment confidential. Staff closed curtains around patients’ beds when delivering care, which protected patients’ privacy and dignity. We saw that staff knocked on doors or announced themselves and waited for a response before entering rooms or curtained off areas. Staff were able to shield information about patients, such as white board information, from public view. Most computer screens were positioned so they could not be viewed by unauthorised people. Access could only be gained through secure password access. Staff kept most paper records securely and away from public view.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff understood and appreciated the different social, cultural and religious needs of their patients. Staff told us about the chaplaincy service and that the trust offered a chaperone service. Staff recognised some patients wishes for care to be given by particular gender staff members and described the actions they would take to ensure this.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us they understood staff explanations of their care and treatment. They were involved in decisions about their care and treatment. One patient told us they had been involved in the ward round and were aware of their treatment plan. We saw staff introducing themselves and their role, and they involved patients when speaking with them or carrying out tests, such as taking blood.

Medical care (including older people's care)

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff gave patients time to ask questions if they were unsure about anything. They spent time with patients who were unsure of their surroundings or who were confused and needed additional support. We saw that staff showed understanding towards patients living with dementia; they spoke with them in an appropriate manner, re-explaining things in a different way if the person did not understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients provided feedback by completing surveys, and through the complaints and accolades process. Data provided by the trust showed between April 2021 and January 2022, patients level of satisfaction ranged from 86-100% across all but one medical wards, with the average level of satisfaction of 94%. The exception to this was the ambulatory care unit with an average level of satisfaction of 71%.

Is the service responsive?

Inspected but not rated

We inspected but did not rate this service.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Trust staff understood the different requirements of the local population and ensured they took action through the planning, design and delivery of services to meet the needs of local people. Managers worked collaboratively with external agencies, such as clinical commissioning groups (CCGs), general practices and neighbouring NHS trusts, to improve services provided by the trust.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff were familiar with the importance of same sex accommodation and we saw there were single sex bays, toilets and shower facilities on all wards. Data provided by the trust showed there were no mixed sex breaches from December 2021 to February 2022.

Facilities and premises were appropriate for the services being delivered. The trust reviewed ward configuration and the purpose of each ward as a result of the COVID-19 pandemic. This enabled them to continue to provide care for patients without COVID-19 but allowed them to respond to increased or decreased demand for patients with COVID-19.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. Staff worked well with local teams to care and manage treatment for patients living with a mental health condition or a learning disability. They explained the role of the Learning Disability specialist nurse and the support they received when there was a patient with a learning disability on the ward.

Medical care (including older people's care)

The service had systems to help care for patients in need of additional support or specialist intervention. Specialist nurses were available and assisted staff with the management of patients admitted to the hospital with various medical conditions. One specialist nurse visiting a ward described how their role ensured staff had appropriate support and advice to provide the correct care to patients who were on different wards. This staff member also liaised with another NHS trust when patients had been referred to or received treatment there.

The service relieved pressure on other departments when they could treat patients in a day. Staff referred patients to the ambulatory care unit when they were assessed as able to be discharged after receiving short-term, same day care. Patients were seen in the ambulatory care unit and provided with treatment and return appointments if required. This provided a good range of admission avoidance options, with the unit taking between 30 and 55 new patients a day. The ambulatory care unit was open every day between 8am and 8.30pm. However, staff commented that they quite often worked late for several hours when patients were transferred late to the unit or needed admission to a ward, but no beds were available.

Patients who were able to sit in a chair for treatment, rather than needing a bed, were also cared for and treated in the medical admissions unit. This unit could accommodate up to four patients in this way.

Access and flow

People could access the service when they needed it but did not always receive care promptly due to pressures on bed capacity. There were a high number of patients unable to leave the hospital as they waited for onward packages of care.

Bed occupancy at Peterborough City Hospital was at full or near to full capacity in the three months before our inspection and this was higher than the East of England and England averages. Managers recognised the service had capacity issues with available beds due to the high number of patients who were medically fit to be discharged but were delayed. Information submitted by the trust about national statistics showed delayed discharge numbers were lower than many other trusts in the East of England until December 2021. However, numbers had increased month on month since then.

On the day of our inspection there were 75 patients waiting to be discharged who could not be for several reasons. Most staff told us discharge delays were largely due to challenges arranging social care, such as care homes. Information provided by the trust showed delays for approximately two-thirds of delays were due to external social care reasons. However, a third were due to internal factors such as pharmacy/medicines or diagnostic tests delays. This included waiting for COVID-19 test results.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Information from the trust showed internal hospital issues, such as a variable standard in staff completing discharge information and required equipment not being requested, were also some of the factors that contributed towards delays. Managers told us the discharge team looked at these issues every day to identify why and where delays were due to medical reasons, which was fed back to the relevant medical team. Managers had developed improvement programmes and initiatives to look at the reasons for the delays and how these can be improved.

Managers monitored waiting times; however, although patients could access services when needed, they did not always receive treatment within agreed timeframes and national targets. Staff told us this was due to the significant strain on capacity in services both internally and externally.

Medical care (including older people's care)

The service had systems in place to try and improve access to treatment. Most patients were admitted to medical wards either directly from the emergency department (ED) or from the medical assessment unit (MAU). Staff told us the length of stay in MAU and the medical short stay unit (MSSU) had sometimes increased beyond what was clinically expected. This was a result of demand on beds elsewhere in the hospital and patients being found a bed in areas which were not those planned for their care and treatment. However, the average length of stay in both MAU and MSSU in the four weeks before our inspection was 57 hours. This was within the expected length of stay for MSSU, which was 75 hours, but longer than that for MAU, which was 45 hours.

The biggest impact was in the ambulatory care unit. This meant that staff worked beyond their finish times, sometimes by up to three and a half hours, to ensure patients received the appropriate care and treatment, or were transferred to another ward in the hospital. Both managers and staff said patients would often be transferred there who needed admission or would not be able to leave within the working hours of the unit.

Staff tried not to move patients between wards at night. However, data provided by the trust showed in the four weeks before our inspection this occurred 1,020 times. This was an average of 36 patients moved each night, of which two thirds were new admissions or discharges and one third (15 patients) were transferred between wards.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards (known as outliers). Managers discussed the number of these patients at site meetings and attempted to reduce the number of outlying patients. However, this was made more challenging by the bed capacity pressures on the service. There were 47 medical outliers on the day we inspected, and these patients were mainly situated on specific wards. Arrangements had been made to support these wards with consultants and dedicated junior doctors, so that medical reviews of care could be completed in a timely way.

Staff supported patients when they were referred or transferred between services. Many specialty services had clinical nurse specialist roles to monitor and support staff and patients on different wards or when they were transferred to other services. A surgical specialist nurse described how they also supported patients who had been admitted for another reason but were either known or referred to the specialism.

Is the service well-led?

Inspected but not rated

We inspected but did not rate this service.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust had an established leadership structure within the emergency and medical division. This included a divisional director, divisional operations director, and a divisional nursing director. They were supported by associate divisional directors, operational managers, clinical leads, matrons and ward managers.

Medical care (including older people's care)

We met with the divisional leadership team (DLT) who spoke with pride about the work and care their staff delivered on a daily basis. The team demonstrated an awareness of the service's performance and the challenges they faced. However, they recognised further actions were needed to address the challenges, including more cohesive working with system partners and more streamlined patient pathways.

The leadership team were committed to developing a more coordinated approach to enable quality improvement to be embedded across the service. Senior leaders were involved on a day to day basis, to support a safe and effective approach to clinical staffing and patient flow. However, this was challenging given the pressure the service was facing. Leaders were aware of issues with delayed discharges impacting flow and had developed a plan to address them. This included working collaboratively with a number of partners, both internal and external, to lead on a programme of work designed to provide improvements in flow across the hospital.

Other initiatives to improve the flow through the hospital included the relaunch of long length of stay meetings, collaborative approach to multidisciplinary team (MDT) teaching to ensure patients are referred for discharge support, three patient flow coordinators to work alongside the discharge planners, and targeted ward based teaching in patient flow initiatives. Managers were developing key performance indicators to measure success and highlight areas for improvement.

Ward managers were organised and demonstrated strong and supportive leadership. They were knowledgeable about the ward's performance against the trust priorities and the areas for improvement.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They did not always identify relevant risks and issues or take actions to reduce their impact. They had plans to cope with unexpected events.

The service had arrangements in place for identifying, recording and managing risks. The emergency and medical division had a risk register, which included a description of each risk and the lead person responsible for reviewing and monitoring. The risk register was monitored within the governance framework and regularly reviewed. However, entries to the risk register did not correspond with concerns we had during our inspection. There were four entries in relation to reduced staffing levels, none of which recognised the trust's division wide staffing issue but were regarding individual staff members. Although a more recent development, managers had also not added the increase from December 2021 of delayed discharges to the risk register, or the continued availability of air flowmeters.

The trust had assurance systems in place, and performance issues were escalated appropriately through established structures and processes. These included processes to manage current and future performance, which were regularly reviewed at specialty and divisional meetings. Staff completed a systematic programme of clinical and internal audit to monitor quality, and systems were in place to identify where action should be taken.

Managers monitored key quality performance indicators and reported these monthly to the trust board. They covered a wide range of quality indicators, including number of pressure ulcers and falls, infection control indicators, incidents, response to treatment times, complaints, and friends and family test results.

Managers from the service took part in daily site meetings which had a focus on improving flow through the hospital where possible. These meetings were attended by colleagues from across both hospital sites meaning risk could be considered as an overall trust and shared.

Medical care (including older people's care)

The trust had a policy and plans in place for emergencies and other unexpected or expected events, such as adverse weather, flu outbreak or a disruption to business continuity.

Areas for improvement

Action 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 trust MUST take to improve

- The service must ensure National Patient Safety Alerts are actioned, specific to airflow meters. (Regulation 12 (1) (2) (a) (b) (d) (e))

Action the trust SHOULD take to improve

- The service should ensure they continue to regularly review the nursing and medical staffing levels in order to increase these to meet establishment levels. (Regulation 18)
- The service should ensure they continue to review delayed discharges, work to resolve causes within the hospital system and continue work with external agencies and providers to improve the current number of delays. (Regulation 17)

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

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

Mandatory training

The service provided mandatory training in key skills in relation to patient risk however, not all staff had completed it.

Nursing and medical staff were not up to date with their mandatory training in key skills relating to patient risk. The service set a 90% compliance target for all staff regarding their mandatory training which covered a wide range of subjects including infection prevention and control (IPC), life support, and safeguarding adults and children.

Data supplied by the service following our inspection showed nursing staff achieved between 77% and 96% compliance for their annual IPC training and medical staff compliance ranged between 75% and 82%. Nursing staff achieved between 72% and 94% compliance for annual sepsis training and between 66% and 85% for their adult practical sepsis competencies. Nursing staff compliance with paediatric practical sepsis competencies was 60%.

Medical staff achieved between 12% and 18% for their three-year sepsis training, the service did not provide any annual training data in relation to sepsis for medical staff.

Nursing staff compliance with adult basic life support ranged between 83% and 87%, medical staff compliance ranged between 74% and 79%. Nursing staff compliance for immediate life support training ranged between 65% and 73% and 60% for advanced life support. Medical staff compliance for advanced life support training ranged between 50% and 75%. Data in relation to the paediatric ED showed no medical staff had completed paediatric life support training and 44% of nursing staff achieved compliance, it is to be noted this was a much smaller staff team.

Managers monitored mandatory training and alerted staff when they needed to update their training. The ED had two clinical educators who worked with the staff team to improve compliance with training and ongoing clinical competencies. The clinical educators undertook daily walkarounds within the ED and were expected to sign off competencies for all staff. The clinical educators told us this could be difficult as there was not always enough time, and they also had responsibility for rostering competencies for all staff. The COVID-19 pandemic had impacted on staff capacity to complete mandatory training, some of which was undeliverable as it required face-to-face contact.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. The service' risk register included safeguarding training and was recorded as a high risk. The service had agreed a 50% staff compliance target for safeguarding training with the local clinical commissioning group (CCG) during 2021 and 2022.

Urgent and emergency services

Data supplied by the service following our inspection showed 72% of nursing staff were in date for level two or three children's safeguarding training and 71% of medical staff were in date for level three. Nursing staff achieved 67% for level two or three adult safeguarding training and 91% of medical staff were in date for level three.

All staff receive safeguarding training as part of their induction and all staff were compliant to level one safeguarding training. At the time of producing the data the service told us all members of the ED nursing or medical staff had received safeguarding training since entering the service.

Staff we spoke with knew how to identify adults and children at risk of or suffering significant harm. The service had processes to identify patients who were frequent attenders, and those who attended with unexplained injuries.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff routinely cleaned equipment after every patient contact. However, staff had not used any labelling to show when the equipment had last been cleaned. Domestic staff completed daily records that showed cleaning had taken place in key areas. Data supplied by the service showed the service achieved above 94% compliance routinely between April 2021 and January 2022 with ED cleaning schedules.

Staff followed infection control principles including the use of personal protective equipment (PPE). At the time of our inspection, staff were following the service's COVID-19 Amber pathway. All patients arriving at the ED were asked if they had any COVID-19 symptoms, staff then followed the Amber pathway. Patients entering the ED with suspected COVID-19 were placed in a dedicated bay until they had completed a COVID-19 Lateral Flow Test. If the patient tested positive, they were then moved to a side room.

The service had improved its resuscitation area, which had eight sealed rooms that could be used to isolate patients who had tested positive for COVID-19 or other patients likely to pose high risk to patients or staff and to reduce the risk of cross infection.

Staff followed, 'bare below the elbow' guidance, and wore PPE such as gloves and aprons whilst delivering care, in line with service policy. Hand hygiene audits from April 2021 to November 2021 showed 100% unchallenged compliance. This fell to 95% in December 2021 and 91% compliance in January 2022. However, following our inspection the trust provided information that demonstrated following challenge hand hygiene compliance was at 100%.

Hand washing facilities, alcohol gel and hand conditioner were available throughout the ED. Clear signage was in place to remind staff, patients and visitors of the importance of infection control.

Environment and equipment

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

Urgent and emergency services

The design of the environment did not always follow national guidance. At the height of the COVID-19 pandemic, the service altered its ED environment to provide safe pathways to manage patients likely to pose an infection risk to other patients and staff. During our inspection, the service was following its Amber COVID-19 pathway and there were no longer significant environmental restrictions in place. Staff were encouraging social distancing, however at the time of our inspection we observed patients were sitting directly next to each other in reception areas.

Staff did not always carry out daily safety checks of specialist equipment. Records we reviewed showed staff had not always completed daily checks on resuscitation trolleys, however equipment within the trolleys was in date and serviced. Staff we spoke with told us this was due to the increased patient demand within the department which meant these checks were not always prioritised.

Since our inspection in December 2020, the paediatric assessment unit had moved to a new location. The children's waiting area was not visible from the nurses' station. It had a full-size door with no way of controlling entry or exit. This meant if a child deteriorated or attempted to leave this area unsupervised, they may not be seen. The main doors to the children's ED were locked and key fob controlled, with a high-level exit button, but there was no CCTV. This meant that observation of this area was restricted.

The development of the urgent treatment centre (UTC) had created an additional 17 dedicated treatment rooms and eight cubicles. Children were seen waiting alongside adults in the UTC waiting area, staff told us this was not ideal, and it was on the services risk register.

The service had built three initial assessment rooms in its main reception where staff could carry out initial triage in private for walk in patients. Patients could access the NHS 111 touch online service tool through touch screens in the ED main reception for guidance on care pathways, book general practitioner appointments or be guided to alternative care services.

The service had made physical improvements to its resuscitation areas, which now had sealed bays to reduce the risk of cross infection and improve patient dignity and privacy. We were concerned this would lead to limited staff oversight of patients in each bay. However, the service was implementing a new patient monitoring system in March 2022 to aid patient monitoring.

Patients could reach call bells and staff responded quickly when called. During our inspection we noted patients had call bells where appropriate and staff answered call bells in a timely manner.

The service had suitable facilities to meet the needs of patients' families. The service had maintained its private and family areas for adults, during the COVID-19 pandemic including an area where 'last offices' could be given. The term 'last offices' relate to the care given to a person after death. It is a process that demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs, as well as health and safety and legal requirements.

The children's ED had a quiet room for patients living with autism, learning disabilities or complex communication needs. This room was still being renovated at the time of our inspection and as such was not suitable for supporting patients who may have additional mental health needs. Staff used two open cubicles next to the nursing station for any patients who needed additional mental health support so they could be observed in line of sight. The service had a dedicated room for adults who required additional mental health support, and this met national guidance.

The service had enough suitable equipment to help them to safely care for patients. During our inspection we noted staff had access to a wide range of equipment to enable them to treat and care for patients. Equipment was stored appropriately, and corridors were not crowded. There were systems in place to ensure the regular maintenance of equipment took place.

Staff disposed of clinical waste safely. Staff ensured clinical and domestic waste bins were segregated appropriately, dated and signed.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient comprehensively to remove or minimise risks or update the assessments.

Patients arriving by ambulance used a dedicated ambulance entrance for both adults and children. Adults then proceeded to the ED assessment and treatment areas, majors or minors, or resus areas. Children were either taken into the children's resuscitation area or the children's ED. The service had a dedicated helipad and a walk-in reception for patients arriving by foot to its main ED and Urgent Treatment Centre (UTC).

Hospital ambulance liaison officers (HALO) employed by the local NHS ambulance service worked alongside the ED team to support patient flow. This gave the opportunity to pre-alert staff if a patient required additional support and direct patient flow through the ED.

Staff used a nationally recognised tool to identify deteriorating patients, however these were not always completed in full. The service used the national early warning score system (NEWS2) for adults and the paediatric early warning score (PEWS) for children. An early warning score is a guide used by medical services to quickly determine the degree of deterioration of a patient. It is based on the vital signs of respiratory rate, oxygen saturation levels, temperature, blood pressure and heart rate. We reviewed six sets of children's patient records which showed staff had not fully completed the PEWS charts.

The service told us there was no formal requirement for PEWS training to be delivered to medical staff. This was due to medical staff receiving comprehensive training in the recognition, assessment and management of an unwell child. Data provided by the service following our inspection showed nursing staff achieved 88% compliance with PEWS training.

According to the Matrons balance score card, which audited five patients a month, staff compliance with PEWS scoring varied in the twelve months before our inspection. The service achieved 100% compliance in September and October 2021. The service achieved above 94% for the months of January, April, July and August 2021 but failed to achieve above 87% for the remaining months. Nursing staff compliance with adult NEWS completion was routinely above 97% during the same period.

Staff used the Manchester Triage process when completing initial patient assessments. During our inspection we reviewed the initial triage times for ten adults and six children. Patient records showed eight of the adults and five of the children were triaged within 15 minutes of arrival by ambulance and streamed to the appropriate area within the ED. Staff monitored waiting times directly from the electronic patient record and escalated patients who were waiting too long to be seen.

Data supplied by the service following our inspection showed compliance against the 15-minute triage target for adult patients remained consistently below 43% during the twelve months before our inspection. Compliance against the 15-minute triage for paediatric patients declined monthly from 56% in February 2021, to 25% in February 2022.

Urgent and emergency services

Staff knew about specific risk issues, however patient documentation in relation to risk was not always completed in the records we reviewed. For example, one adult patient and one child record showed the Sepsis Six documentation was incomplete or had not been signed or appropriately documented. The 'Sepsis Six' is a set of six tasks including. oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring, to be instituted within one hour by non-specialist practitioners at the front line. Patient records in relation to children showed a lack of risk assessments being completed, no evaluation of care, and no assessments of hidden harm. One adult care record had no cannula care plan and the patient had a canula in situ and one adult patient record showed no ongoing nursing documentation.

Following our inspection, the service provided data which showed in the twelve months before our inspection staff compliance with the patient safety check list was 26% at its lowest and 64.2% at its highest. Seven out of the 10 adult patient records showed only partial completion of pressure assessments being completed, however the records did show patients were transferred to pressure relieving equipment in line with the trust's guidance.

Data supplied by the service following our inspection showed compliance with adult sepsis screening varied between April 2021 and January 2022. The service set a 90% compliance for Sepsis screening and starting to treat patients presenting with sepsis within one hour. From April 2021 to January 2022, the service achieved 90% compliance or above every month except for August 2022 and January 2022 in relation to starting to treat patients within one hour.

Staff achieved 100% compliance with Sepsis screening in October and December 2021. They achieved 90% compliance in June 2021 and January 2022, all other months in the same period fell below the 90% compliance rate. The data in relation to providing Sepsis treatment for paediatrics was poor, the service only achieved 100% compliance in April and August 2021. May, July and December 2021, showed 0% compliance and the remaining months had no data completion.

In the twelve months before our inspection the time from patient arrival to the time of intravenous (IV) antibiotics being administered for the treatment of sepsis varied greatly. Data supplied by the service following our inspection showed in January 2022, 77.7% of patient received antibiotics within an hour, 11.1% within one to two hours and 11.1% waited above three hours.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff within the ED had access to mental health liaison staff 24 hours a day, seven days a week.

Staff shared key information to keep patients safe when handing over their care to others. This was done by using a blend of written and electronic patient records.

The service had an up-to-date policy for the management of upper gastrointestinal haemorrhage in adults. The out of hours upper gastrointestinal haemorrhage consultant was available on both Peterborough City Hospital and Hinchingbrooke Hospital sites after 5pm (Monday to Thursday) and an across site service was available from Friday 5pm to Monday 8.30am.

Staffing

Nurse staffing

The service had enough nursing staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.

Urgent and emergency services

The service had enough staff to keep patients safe from avoidable harm and to provide the right care. Following our inspection, the service told us that managers use two separate IT systems to plan its workforce. They also told us that a cross divisional bronze staffing cell took place daily at 8.30am. Staffing data was reported through the monthly staffing report and the trust undertakes six monthly staffing reviews in line with National Quality Board recommendations for all clinical areas, which are reported through the services People and Culture Sub-Board Committee and services Board.

On the day of our inspection the number of nurses and healthcare assistants did not match the planned numbers. The manager had taken appropriate steps to provide some cover for sickness absence. Staffing levels were displayed, as well as the name of the nurse in charge and emergency physician in charge (EPIC).

The department manager could adjust staffing levels daily according to the needs of patients. Managers used safer staffing tools to plan resources against patient acuity. Staff we spoke with told us staffing levels and skill mix was on the risk register and recruitment was an ongoing challenge due to the nature of the workload in the ED and nursing in general.

The service had a reducing vacancy rate and aimed to achieve below 5%. From March 2021, the nursing staff vacancy rate had reduced on a monthly basis from 25.44% to 11.69% in February 2022.

The service had reducing turnover rates and aimed to achieve below 10%. From March 2021, the nursing staff turnover rate was low and had reduced from 1.69% in March 2021 to 0.47% in February 2022.

The service aimed to achieve below 4% sickness absence. Sickness rates increased between February 2021 and June 2021 from 5.18% to 8.34%. Rates then reduced monthly from July 2021, to 8.63% in November 2021. The rate increased again in December to 10.21%, and increasing again to 10.81 % in January 2022. COVID-19 had been a significant impact on staffing levels.

The service showed consistent use of bank and agency staff, data provided by the service following our inspection showed in February 2022, nursing agency staff usage was 16.62% and 9.8% bank staff. Managers we spoke with told us they tried to limit the use of bank and agency staff and requested staff familiar with the service when booking agency or using bank staff. Managers had identified further work was required to improve the consistency of orientation to the ED for both bank and agency nurses. They had developed a bespoke form to formalise orientation to the ED by non-substantive staff, but the process was ad hoc and needed more embedding. Work on this process was due to be completed by 31 March 2022.

Staff we spoke with in the children's ED told us there were not always two registered children's nurses (RCN) on duty in the children's ED. Staff we spoke with told us ongoing recruitment was in place, but recruitment to the RCN roles had been challenging. The teams did aim to cover paediatric shifts through obtaining support from RCN from the paediatric wards where possible as part of the services escalation processes, through the bronze cell daily meetings at 8.30am. The ED manager told us they ensured there was always a nurse on duty who had completed their paediatric competencies and the team also used long line agency nurses with specific paediatric competencies. Two ED consultants had completed additional paediatric training to provide support and the paediatric department was located near to the children's ward, with access to a paediatric consultant on call 24 hours a day.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Urgent and emergency services

The service had enough medical staff to keep patients safe. Medical staffing met with Royal College of Emergency Medicine (RCEM) recommendations of 16 hours of consultant presence per day, seven days a week with the remaining eight hours being covered by an on-call system. Staff told us the consultant team often worked over their allotted hours to provide ongoing support to the patients and staff.

In addition to 16-hour consultant presence cover, there was consultant cover available on-call for evenings and weekends' and appropriate cover for paediatrics.

The service aimed to achieve below a 5% vacancy rate. Vacancy rates fluctuated over the 12 months before our inspection but stayed below 5% except for June, August and September 2021. The vacancy rate increased again in January 2022, to 14.19% this reduced again in February 2022 to 13.1%.

The service had low turnover rates for medical staff. The service aimed to achieve below 10% staff turnover. In the 12 months before our inspection the service achieved below the 10% target monthly except for August 2021.

Sickness rates for medical staff were low. The service aimed to achieve below 4% sickness absence. The service achieved below the 4% target for the 12 months before our inspection.

Managers could access locums when they needed additional medical staff. Data supplied by the service from February 2022 showed a 13.35% use of bank staff and 86.65% use of locum staff to cover any shortfalls.

Records

Staff did not always keep detailed records of patients' care and treatment.

Staff used a blend of paper based and electronic record systems, and we found patient notes were not always comprehensive. For example, out of the 10 adults and six children records we reviewed, one adult patient and one child record showed the Sepsis Six documentation was incomplete, had not been signed or appropriately documented.

One adult care record had no cannula care plan, the patient had a canula in situ and one adult patient record showed no ongoing nursing documentation.

Seven adult patient records showed only partial completion of pressure ulcer assessments being completed, however the records did show patients were transferred to pressure relieving equipment line with the trust's guidance.

When patients transferred to a new team, there were no delays in staff accessing their records. As some of the patient records were electronic, this enabled a wide range of appropriate professional staff to review and update patient records.

Records were stored securely. Staff stored patient records securely and locked computer screens when not in use.

Medicines

The service had systems and processes to safely prescribe, administer, record and store medicines, these were not always followed.

Staff were using both paper based and electronic systems and there was a risk that patient information could be missed or duplicated.

Urgent and emergency services

Staff did not follow a policy to enable patients to safely self-administer their own medicines. Staff told us patients asked if they could take their regular medicines themselves. There was no process to assess the level of support patients required to take their medicines. This meant those patients who required additional support to take their medicines did not always receive their medicines on time.

Medicines were not always stored safely. Resuscitation medicines were not stored securely, cupboards were open and not supervised. Managers told us this is currently required due to the urgency of staff needing access to medication in 'Resus'. However, the service was implementing a solution to address this and this was a known issue on the services risk register. Medicines in the resuscitation cupboards were not stored in an orderly way and different medicines were mixed in the same box. This could delay staff from locating the correct medicine or increase the likelihood of incorrect selection. Part used fluids were not disposed of appropriately. Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff conducted medicines reconciliation when patients were transferred to the medicine's admission unit. (Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use.) Staff used GP summary care records for information about patient's medicines. However, not all GP practice summary care records were linked to the hospital system.

The service ensured patient's behaviour was not controlled by excessive and inappropriate use of medicines. The service had a policy for the use of rapid tranquilisation.

There was a plan to have an ED pharmacist and there was a concern that patient flow across the separate sections in the ED could result in missed opportunities to undertake a full medicines reconciliation.

Is the service caring?

Inspected but not rated

We inspected but did not rate this service

Compassionate care

Staff were not always discreet when caring for patients or attentive to their needs.

During our inspection we noted staff were not always discreet when caring for patients. An example was a patient approaching a member of staff at the nursing station and requesting the toilet. The staff member then turned to a colleague and said, "This patient needs the toilet", the colleague then shouted across to another member of staff, "This patient needs the toilet." This was not discreet and showed staff did not recognise the impact of their actions on the patient involved.

During our inspection, we heard some staff calling patients "Lovie", "darling" and "sweetheart", and not by their preferred name.

On occasions, we had to approach staff and ask them to cover patients to promote their dignity. We also observed staff walk past patients in bed in a state of undress and take no action.

Urgent and emergency services

We spoke with five patients and two relatives who told us staff treated them well and with kindness. Another patient told us they were a frequent attender, and staff on the reception and security were rude and the environment was always dirty.

Is the service responsive?

Inspected but not rated

We inspected but did not rate this service

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Leaders worked with external stakeholders to respond to increased patient demand and meet the needs of the wider health care economy. Leaders were engaged with community health services, primary care services and other NHS organisations to adapt emergency department (ED) services. For example, implementing general practitioner (GP) services within the ED to stream patients more quickly and safely and avoid hospital admissions while reducing patient waiting times.

The service had made improvements to the physical environment in order to manage increased demand and in response to the COVID-19 pandemic.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had a rapid response and frailty team who provided urgent assessment of frail older patients coming into the ED. The service ensured patients received appropriate care, including avoiding admission where possible.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients living with mental health problems, learning disabilities and dementia.

The service relieved pressure on other departments when they could treat patients in a day. The urgent treatment centre (UTC) worked with partners to provide GP services and provided a range of treatments for minor injuries in order to reduce hospital admissions. The service had a frailty team who could support patients with early intervention, and work with community reablement teams to avoid patients being admitted.

Managers we spoke with explained how they planned to engage with staff to improve flow and services for people. This was to include looking at external services that could be accessed before admission, pathways on admission and discharge. Leaders were specifically exploring how discharge planning and the use of weekend staff cover could improve flow through the hospital.

Access and flow

People could not access the service when they needed it, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Urgent and emergency services

Managers monitored waiting times and patients could access emergency services. However, due to demand at times, not all patients received treatment within agreed timeframes and national targets.

Managers told us due to the impact of the COVID-19 pandemic, many meetings regarding flow and capacity had been held online and they used an IT based bed tracking system to view where patient capacity was available.

Managers and staff in the ED started planning each patient's discharge as early as possible, but some patients were waiting long periods for decisions regarding their care and treatment, and decision to admit or discharge. (Decision to admit refers to the time a decision is made to admit the patient to a hospital bed). At the time of our inspection bed occupancy on the medical and surgical wards, (the main receiving wards when patients were transferred from the ED) was above 99%. This level of bed occupancy made it difficult to move patients from the ED for admission into the ward areas. Factors such as high bed occupancy, discharges, waiting for additional clinical review were key factors affecting patient waiting times in the ED.

The service introduced a rapid assessment and treatment process (RAT) in August 2020, which was consultant-led between the hours of 10am to 8pm, with the ED consultant cover continuing for 16 hours out of every 24. Whilst the service aimed to use this area for rapid assessment and treatment, we noted during our inspection one patient had been in the RAT area for over five hours due to capacity and access to other areas of the hospital.

The Department of Health and Social Care's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. In the 12 months before our inspection the service had not achieved this target. In February 2022, 52.73% of patients were admitted, transferred or discharged within four hours of arrival. Patients were waiting for extended periods within the ED due to the wider hospital capacity issues.

Data supplied by the service following our inspection showed the percentage of patients waiting over four hours from the decision to admit had been worse than the East of England average and the England average since February 2021. In October 2021, 74.95% of patients waited over four hours compared to the England average of 30.7% and the East of England average of 24.9%. At the time of our inspection, the percentage of patients waiting over four hours from the decision to admit to admission was 84.69%, this was due to capacity issues in the hospital and the inability to move patients from the ED.

Data supplied by the service following our inspection showed the number of patients leaving the service before being seen for treatments increased from 1.01% in February 2021, to 6.33% in September 2021. The percentage of patients leaving the service before being seen for treatments decreased from 6.33% in September 2021 to 4.55% in January 2022, with a slight increase in February 2022 to 5.42%.

From February 2021 to February 2022, the number of patients waiting for 12 hours or more in the ED had increase monthly, and during the 12-month period 10,415 patients had waited over 12 hours in the ED. The three areas of note were 5,892 patients waited due to capacity issues, 1,924 were due to delay in speciality review from medicine and 1,332 were due to waiting for an ED clinician.

Data supplied by the service following our inspection showed a steady increase in the median time to initial assessment (emergency ambulance cases only). In April 2021, the median time from arrival to triage was 82 minutes, this increased monthly to 149 minutes in August 2021. There was improvement from September 2021 to January 2022, and times increased again in February and March 2022, to 140 minutes and 162 minutes respectively.

Urgent and emergency services

The percentage of ambulances journeys with turnaround times over 60 minutes had increased monthly from June 2021, which coincided with much higher total attendances at the ED. Data supplied by the service following our inspection showed in May 2021,13.74% of ambulances had handover delays over 60 minutes, this increased to 24.79% in June 2021. At the time of our inspection, we noted delays in ambulance handovers and the service was boarding patients in corridors. Boarding refers to the process of moving patients from the ED to a non-identified bed space on a ward area whilst awaiting admission, which allows for ED overcrowding to be relieved.

In February 2022, 33.48% of ambulance handovers were over 60 minutes, this was due to a lack of capacity to move patients into ward areas, which meant ED staff had to keep patients within the ED longer than necessary. The service had escalation processes and policies in place to manage any deteriorating patients and oversight of patients boarding in corridors or waiting on ambulances.

Managers and staff aimed to make sure patients did not stay longer than they needed to. The service implemented a patient boarding policy. Reverse boarding is the practice of moving patients who are awaiting discharge into a suitable area on the ward to allow for an additional admission, usually from Medical Assessment Unit (MAU), Short Stay Unit (SSU) or ED, to aid patient flow and capacity through the hospital site. Data supplied by the service showed the policy was used at times of high demand to try and relieve pressures within the ED.

The percentage of ambulance offloading within 15 minutes was routinely low, the service achieved 18.05% against this measure in March 2021, and the percentage then declined monthly to 5.27% in December 2021. This percentage improved slightly in January and February 2022, at 7.77% and 13.38% respectively.

Patients could access the NHS 111 online self service tool through touch screens in the ED main reception for guidance on care pathways, book general practitioner appointments or be guided to alternative care services.

Is the service well-led?

Inspected but not rated

We inspected but did not rate this service.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced however, they did not always manage them appropriately. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department (ED) had a clear leadership structure, with defined roles and responsibilities. Staff on duty knew who the emergency physician in charge (EPIC) and nurse in charge was and this was recorded on the staff notice board.

The ED management team covered both Peterborough City hospital (PCH) and Hinchingbrooke hospital (HH) sites. There were no leadership vacancies at the time of our inspection. The leadership team included ED consultant leads on both sites, a head of urgent and emergency care across both sites and a dedicated service manager at PCH. The ED matron for urgent and emergency care worked with the ED lead nurse for each site to promote consistency of services.

Urgent and emergency services

We had concerns that whilst leaders understood the priorities and risks within the ED, the performance and patient flow was not being optimised. Examples included the lack of discussion in relation to performance targets during handovers and no visual targets for staff to follow regarding waiting times. Staff we spoke to said they felt uninvolved in the wider discussions regarding performance and leaders and managers did not fully engage with them or update them on the wider hospital issues affecting flow through the ED.

Staff we spoke with told us mangers were visible within the department providing day-to-day support and managers worked closely with them to manage patient care. However, staff described a long-standing culture of being overwhelmed by the number of patients and improvements in patient flow were slow to happen.

Leaders supported staff to develop their skills and knowledge. Clinical educators worked alongside leaders to offer a range of development and training opportunities.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service had a strategic plan and an emergency medicine vision statement. The three-year strategy and annual plan had been published. Four strategic divisional directives included, valuing and supporting our team, recovering effective care, improving our emergency care service and patient flow, and transforming services.

The service had set its strategic objectives for the period 2022 to 2023 and identified measurable outcomes to improve services against each strategic objective. Measurables included but not limited to improvement in urgent and emergency care through a ten-point plan and action plan, improving discharge times, reducing waiting lists and supporting staff to improve sickness absence and better recruitment.

The service's urgent and emergency care priorities for 2022 included improving urgent and emergency care responsiveness, implement time to initial assessment within 15 minutes of arrival and eliminating long waits in the ED. These priorities reflected the concerns we had observed during inspection and identified within the data provided by the service following our inspection.

Managers we spoke with explained they were looking to improve engagement with staff to consider ways to improve flow, from the patients first attendance through to discharge. This included looking at discharge planning, and weekend staff cover to improve flow through the hospital.

The service was working with other system partners to consider and respond to the impact of the Integrated Care Strategy (ICS) strategy. This was a new project, and the leadership team were looking at engagement strategies to ensure all staff were aware of possible changes in services going forward.

The ED team were working collaboratively with wider staff teams to look at the capacity issues to consider what did or did not work and why. The service was aware that delays to discharge were in the main medical issues. The service looked at the wider impact of other issues, for example extended length of stays on wards, any themes affecting discharge and care planning.

The service recognised many of its issues were due to the wider health care system and was looking at ways of challenging the wider system and transferring some risk to other system partners.

Urgent and emergency services

Culture

Staff described a culture of acceptance given the capacity and lack of movement of patients through and out of the hospital. This led to extended patient waits and patients staying for longer than necessary in the emergency and urgent care environment.

During our inspection the ED team described working at full capacity, the feeling of 'facing a wall of patients' daily and there seemed no end to the capacity issues across the service.

Staff told us they felt valued by local leadership, they felt the leadership team were trying their best, but they felt there was a lack of sharing the load across the service. At times the wider teams saw the ED as another ward, where patients could be boarded due to the lack of movement out of the hospital or between specialties.

Due to the lack of staff on ward areas and reduced medical input, specialties were not routinely visiting the ED in line with internal professional standards. This placed additional pressure on staff within the ED, which meant staff took longer term ownership of patient care, when patient numbers attending the department increased. This created a culture where staff felt overwhelmed at times due to the demands within the department.

We spoke with key staff regarding patient flow and how resources were deployed, including the management of discharges. Staff described a culture where some staff and departments were more responsive and interested than others in challenging capacity and making patient moves happen to increase capacity.

Patients could leave feedback in several ways, completing feedback forms and placing these in dedicated feedback boxes, local and national patient surveys, SMS messaging, friends and family tests, through the patient advice and liaisons service (PALS) and by social media.

Governance

Leaders operated effective governance processes throughout the service.

Escalation plans had been brought into effect during the pandemic. The service used a multi-disciplinary approach to managing key challenges within the ED. This included the management of flow using combined operational and clinical meetings with divisional teams to address key issues, for example, staffing levels, escalation and risk.

The service was engaged with the emergency care intensive support team (ECIST), among others, to support the team to make sustainable performance improvements in the ED.

The emergency medicine divisional quality assurance committee held oversight for governance across the service. The service had a ward to board approach towards governance and risk, with several subgroups providing information to the wider teams on issues such as risk and performance. The service held monthly ED clinical governance meetings, covering the ED, medical assessment unit (MAU) and clinical observation decision unit (CODU), an ED operational performance group meeting, an ambulance handover focus group meeting and a children and young people's services steering group.

We reviewed the ED clinical governance meeting records from October 2021 to January 2022 which covered incidents, trends, and themes and lessons learnt, patient safety and risk.

Staff identified and escalated relevant risks and issues, identified actions to reduce their impact and had plans to cope with unexpected events. The ED leadership team held monthly ED risk register review meetings with ED matrons, lead nurses and service managers. These meetings were chaired by the head of urgent care and fed into the formal ED clinical governance meeting.

The ED held monthly open forums to enable the ED leadership team to update staff on key developments in ED and wider urgent care areas. This gave staff group representatives opportunities to feedback on areas for improvement and discuss any challenges that needed addressing, for example any risks or concerns. The service used IT to support wider attendances at team meetings to enabled social distancing and offer flexibility for staff to join meetings and discuss risk.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and took action to reduce their impact.

Leaders and teams used systems to manage performance. Staff we spoke with could describe the process for escalating concerns around capacity and risks within the ED. The service had robust arrangements for identifying, recording and managing risks and mitigating actions. Staff knew the highest risks within the department which related to patient flow, waiting times, staffing levels and ambulance delays.

Staff identified and escalated relevant risks and issues and identified actions to reduce their impact.Managers we spoke with described in detail the risks within the service and how staff were encouraged to report any risks or concerns to the manager in charge or by using the service incident management processes. The risks staff described were recorded on the service risk register. All risks had risk owners assigned, detailed the mitigating actions in place and had been reviewed regularly.

An example of the service managing risk included the actions taken to mitigate the lack of audio and visual oversight of patients following reconfiguration of the ED resuscitation areas. The service was due to introduce a new patient monitoring system into this area, to improve patient oversight and identify patients who may deteriorate.

Managers monitored performance of the service using a programme of internal and external audit. Staff we spoke with told us audit data was shared at team meetings, during staff handovers and safety briefings and from feedback by email.

Staff could access ED performance data by a dedicated screen on the services IT system. We noted during handover there was a strong focus on patient discharge, and staff did not routinely refer to NHS targets regarding seeing or treating patients. Staff told us these figures were a guide, but the most important factor was ensuring all patients were seen, and safety netted, rather than aiming for performance targets.

The service considered potential risks when planning services and considered alternative care pathways to address changes in demand, for example the implementation of the urgent treatment centre to manage minor injuries and health conditions and the general practitioner (GP) streaming service.

Escalation processes were embedded within the service to deal with increased demand, the challenge of the wider hospital capacity issues and the impact of delayed waits on patients remained a significant concern for the ED service.

Urgent and emergency services

Areas for improvement

Action the trust MUST take to improve

- The service must ensure all staff complete checks on emergency equipment in line with service policy and guidance. (Regulation 17 (1) (2) (b))
- The service must ensure it provides mandatory training in key skills to all appropriate staff. (Regulation 17 (1) (2) (b))
- The service must ensure the design, maintenance and use of facilities, premises always keep people safe (Regulation 15 (1)).
- The service must ensure staff complete risk assessments for each patient comprehensively to remove or minimise risks and update the assessments. (Regulation 17 (1) (2) (b) (c))
- The service must ensure staff keep detailed records of patients' care and treatment. (Regulation 17 (1) (2) (b) (c))
- The service must ensure staff complete safety check lists, and that sepsis screening is completed on time to enable effective treatments to be administered to limit patient harm. (Regulation 17 (1) (2) (b) (c))
- The service must ensure that staff follow systems and processes to safely prescribe, administer, record and store medicines. (Regulation 12 (1) (2) (g))

Action the trust SHOULD take to improve

- The service should ensure staff are always discreet when caring for patients and attentive to their needs. (Regulation 10)
- The service should ensure staff label equipment following any cleaning activities. (Regulation 17)
- The service should ensure people can access the service when they needed it, and that waiting times from referral to treatment and arrangements to admit, treat and discharge patients are in line with national standards. (Regulation 17)