Alexandra Hospital

Quality Report

Woodrow Drive
Redditch
Worcestershire
B98 7UB
Tel: 01562513240
Tel: 01562513240
Website: www.worcsacute.nhs.uk

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at the Alexandra Hospital on 16 December 2019, in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology. We have rated safe, responsive and well led as inadequate. We have not rated effective and we did not inspect the caring key question. We found that:

Crowding in the emergency department (ED) was our biggest concern. Significantly increased ambulance attendances, combined with the layout of the department and poor patient flow in the hospital, posed a significant risk to patient safety and the department quickly became congested and overwhelmed. This meant that it was frequently very challenging to quickly identify and prioritize patients.There were delays in off-loading ambulances and resultant delays in assessment and treatment for some patients due to overcrowding. There was a risk that the sickest patients may not be identified quickly. Staff were attentive and aware of the riskiest patients; however, nurses' record keeping needed to improve to provide assurance that staff were able to identify and escalate acutely unwell/deteriorating patients.

Whilst the service mostly had suitable premises, there were insufficient cubicles to accommodate all the patients in the department when it was overcrowded. Patients were being cared for in a crowded corridor at the time of the inspection.Patient privacy and dignity was not always protected due to overcrowding.

Triage times were not always in line with guidance. Some patients waited considerable time to be assessed due to overcrowding.Whilst risks to patients were assessed and their safety monitored and managed, not all patients received treatment in a timely manner due to overcrowding.

Whilst there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care at the time of the inspection, consultant cover in the department did not meet recommended guidelines.

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

Leaders understood and tried to manage the priorities and issues the service face but improvements had not been made at the pace required. Plans were still being developed to ease overcrowding.

However:

There were appropriate guidelines and treatment protocols, and these were usually being followed. Staff demonstrated a good understanding of sepsis and were familiar with the trust's sepsis toolkit. Equipment was readily available and systems to ensure emergency equipment was checked had improved, although compliance needed to improve further.

Staff cared for patients with compassion during the inspection. Staff were friendly, professional and caring at all times even when under extreme pressure due to overcrowding in the department. Staff tried but were not always successful in maintaining patient privacy and dignity in times of overcrowding.

There were enough nursing staff with the right qualifications, skills, training and experience to keep adult patients safe from avoidable harm and to provide the right care.

The service had sufficient quantities of suitable equipment which was easy to access and ready for use.

Staff and managers promoted a positive culture that supported and valued each other.

There were areas of poor practice where the trust needs to make improvements.

Summary of findings

Importantly, the trust must:

- Reduce the number of ambulance handover delays.
- Ensure all patients receive timely initial clinical assessments.
- Ensure all patients are seen by emergency department doctors and specialty doctors when needed.
- Reduce the number of patients cared for in corridor areas.
- Consultant cover in the department must meet national guidelines. Trainee consultants must not be classed as 'consultants' on the staffing rota.
- Fully implement the trust wide actions to reduce overcrowding in the department.

In addition, the trust should:

- Review that nursing handovers occur in an appropriate environment which allows privacy for patients and patient details.

Following this inspection, we have taken urgent enforcement action, to impose conditions on the trust's registration to make urgent improvements in the quality and safety of care for patients.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Inadequate 	We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection, the department was under adverse pressure with significant overcrowding. Whilst staff did their best to care for patients with compassion, we found some patients had delays to initial assessments and timely treatments. The trust was implementing a range of actions to reduce overcrowding. We did not inspect any other core service or wards at this hospital. We did not cover all key lines of enquiry. We have rated the service as inadequate overall.

Summary of findings

Contents

Summary of this inspection

Background to Alexandra Hospital

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

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

We previously inspected the emergency department (ED) at Alexandra Hospital in May 2019. We rated it as requires improvement overall. Prior to that, inspections were completed in April and November 2017 to follow up concerns identified in a Section 29A Warning Notice and our comprehensive inspection in November 2017. Previously, the trust was issued two Section 29A Warning Notices under the Health and Social Care Act 2008 and were required to make significant improvements in the quality of care provided. Concerns with the ED were raised in both Warning Notices, which were issued in January and July 2017.

Our inspection team

The inspection team comprised of an inspector and two special clinical advisors. The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

How we carried out this inspection

This was a focused unannounced inspection of the emergency department at Alexandra Hospital on 16 December 2019.

We did not inspect the whole core service, therefore we have not reported against, or rated the effective or caring key questions. We did not inspect any other core service or wards at this hospital, however, we inspected the emergency department at the Worcestershire Royal Hospital using the same inspection methodology on the same day.

During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry. However, because we took enforcement action, we opted to rate the safe, responsive and well-led key questions as detailed in the summary section of this report.

Inadequate

Urgent and emergency services

Safe	Inadequate
Effective	
Responsive	Inadequate
Well-led	Inadequate

Information about the service

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

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

During the inspection, we visited the ED and the EDU. We spoke with 10 staff including registered nurses, health care assistants, reception staff, medical staff, and managers. We spoke with five patients and four relatives, and we reviewed seven sets of patient records.

Summary of findings

We did not inspect the whole core service as this was a focused inspection.

Crowding in the emergency department (ED)was our biggest concern. Significantly increased ambulance attendances, combined with the layout of the department and poor patient flow in the hospital, posed a significant risk to patient safety and the department quickly became congested and overwhelmed. This meant that it was frequently very challenging to quickly identify and prioritize patients.There were delays in off-loading ambulances and resultant delays in assessment and treatment for some patients due to overcrowding. There was a risk that the sickest patients may not be identified quickly. Staff were attentive and aware of the riskiest patients; however, nurses' record keeping needed to improve to provide assurance that staff were able to identify and escalate acutely unwell/ deteriorating patients.

Whilst the service mostly had suitable premises, there were insufficient cubicles to accommodate all the patients in the department when it was overcrowded. Patients were being cared for in a crowded corridor at the time of the inspection.Patient privacy and dignity was not always protected due to overcrowding.

Triage times were not always in line with guidance. Some patients waited considerable time to be assessed due to overcrowding.Whilst risks to patients were assessed and their safety monitored and managed, not all patients received treatment in a timely manner due to overcrowding.

Whilst there were enough medical staff with the right qualifications, skills, training and experience to keep

Inadequate

Urgent and emergency services

patients safe from avoidable harm and to provide the right care at the time of the inspection, consultant cover in the department did not meet recommended guidelines.

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

Leaders understood and tried to manage the priorities and issues the service face but improvements had not been made at the pace required. Plans were still being developed to ease overcrowding.

However:

There were appropriate guidelines and treatment protocols, and these were usually being followed. Staff demonstrated a good understanding of sepsis and were familiar with the trust's sepsis toolkit. Equipment was readily available and systems to ensure emergency equipment was checked had improved, although compliance needed to improve further.

Staff cared for patients with compassion during the inspection. Staff were friendly, professional and caring at all times even when under extreme pressure due to overcrowding in the department. Staff tried but were not always successful in maintaining patient privacy and dignity in times of overcrowding.

There were enough nursing staff with the right qualifications, skills, training and experience to keep adult patients safe from avoidable harm and to provide the right care.

The service had sufficient quantities of suitable equipment which was easy to access and ready for use.

Staff and managers promoted a positive culture that supported and valued each other.

Are urgent and emergency services safe?

Inadequate

Environment and equipment

Whilst the service mostly had suitable premises, there were insufficient cubicles to accommodate all the patients in the department when it was overcrowded. Patients were being cared for in a crowded corridor at the time of the inspection. There were delays in off-loading ambulances and resultant delays in assessment and treatment for some patients due to overcrowding.

In November 2019, 1,925 patients arrived to the ED via ambulance. Patients waiting under the care of an ambulance crew for one hour or more are called a black breach. In the year from December 2018 to November 2019, there were 1,576792 black breaches in this service. In November 2019, there were 113 black breaches recorded at the Alexandra Hospital. During our inspection, we did not see any black breaches at the Alexandra Hospital.

In November 2019, 1,890 patients had been nursed in the corridor. This had increased from the same month in the previous year (November 2018) when it was 1,487. The total time patients spent in the corridor in November 2019 was 2,160 hours. This was an increase from 1,222 in November 2018.

- Trust data showed that in November 2019, there were for Alexandra Hospital:
  - 4,631 attendances.
  - Non admitted, non referred Emergency Access Standard (EAS) performance was 81.23%.
  - Non admitted, referred EAS performance was 43.66%.
  - Category 4 & 5 (Minor) attendances EAS (%) was 85.21%
  - Category 1 to 3 (Major attendances) EAS (%) was 56.83%.
  - Patients in ED over 6 hours was 940.
  - Time in ED - Average (Hours) was 4.5 hours.
  - ED occupancy was 94%.
  - No 12-hour breaches.

Inadequate

Urgent and emergency services

The size and layout of the emergency department (ED) was not always suitable for the number of patients using the service. During our inspection, we saw there was usually four patients at all times being nursed on trolleys in the ED corridor. These patients were cared for by ED staff, who had been dedicated to look after the patients in the corridor. Patients in the corridor did not have access to a patient call bell and some could not easily call a nurse for assistance. Patients were treated on trolleys in the ED corridor where it was not always possible to ensure patients privacy and dignity needs were always protected. Patients requiring procedures which might expose them, for example an ECG, were moved to another area outside of the corridor and which was private. Some conversations between staff and patients treated in the corridor could be heard by those nearby. It was difficult for patients to share personal or confidential information without being overheard by other patients and relatives in the department. Despite staffs' best attempts, confidential information could not always be protected.

Whilst not the primary focus of our inspection, we observed friendly and attentive staff. However, undoubtedly the experience for patients waiting long periods in the department, particularly those accommodated in the corridor, was not a positive one and a few patients complained about this to us and to staff. The outer corridor was the ambulance entrance and it was cold and draughty. We saw a 94-year-old patient who had arrived by ambulance, who was in the ambulance queue for some time. They were cold and in distress because they were in very close proximity to an agitated and vocal patient who was being restrained by police officers, just a few feet away from them. A relative of another patient, who had been in the ambulance queue for an hour and was still on an ambulance trolley in the care of the ambulance crew, complained that their relative was in pain. This was reported to the nurse in charge who came to speak with them.

Patients were in very close proximity to others, queuing both sides of the corridor. This not only made working conditions difficult but also negatively impacted on patients' privacy and dignity. In the corridor in majors, we saw staff moving mobile screens to provide some level of privacy but there was no room to do this in the outer corridor. We understood there was to be some reconfiguration of premises, which would help to free up some more space and allow better sight of the corridor.

Staff apologized when patients' needs were not met and took steps to improve their experience, although this was challenging. We spoke with one patient who had been in the ED for 27 hours and remained on a trolley during this time. Apart from the obvious discomfort, they and their family member were not kept informed about what was happening and when. We were assured by the matron when we gave feedback, that this patient had been transferred to a ward before we left the department.

The ED corridor was not sufficiently wide to accommodate all of the movement in the department when it was crowded. We observed ED staff, porters and ambulance crews juggling with patient trollies and wheelchairs. The lack of space was exacerbated when relatives waited with patients in the corridor. The ED corridor posed a risk to the rapid evacuation of patients in the event of a fire or other emergency. For example, there was insufficient space round each corridor trolley to assist patients if they required immediate resuscitation.

Emergency equipment was readily available, and most staff knew where to locate this. In the resuscitation area, equipment checking systems had improved, although there was still room for further improvement. There was a communication book where staff recorded and missing, or malfunctioning equipment and staff reported at handover if they had been unable to complete equipment checks. There were sufficient oxygen cylinders available, and these were stored appropriately in the department. Clinical and non-clinical staff were aware of the location of the emergency equipment. Its location and how to use it was included the in induction of all staff.

Assessing and responding to patient risk

Whilst risks to patients were assessed and their safety monitored and managed, not all patients received treatment in a timely manner due to overcrowding.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff completed risk assessments for each patient on admission / arrival, using the tool, and reviewed this

regularly, including after any incident. Staff knew about and dealt with any specific risk issues. The ED had a triage system which was aligned to a nationally recognised triage system. This categorised patients according to a risk rating of one to five. For example, level two was a threat to life which required immediate nurse assessment and to see a doctor within 15 minutes; and level four was a moderate risk, to see a nurse within one hour and a doctor within two hours. Triage nurses were able to stream patients to the out of hours GP service that was located next to the ED.

Overall, the sickest patients in the ED were receiving appropriate and safe care; however, there was a risk that they may not be identified quickly. There were appropriate guidelines and treatment protocols, and these were being followed. Staff demonstrated a good understanding of sepsis and were familiar with sepsis toolkits. Staff were attentive and aware of the riskiest patients; however, nurses' record keeping needed to improve to provide assurance that staff were able to identify and escalate acutely unwell/deteriorating patients. Significantly increased ambulance attendances, combined with the layout of the department and poor patient flow in the hospital, posed a significant risk to patient safety and the department quickly became congested and overwhelmed. This meant that it was frequently very challenging to quickly identify and prioritize patients.

Triage times were not always in line with guidance. Some patients waited considerable time to be assessed due to overcrowding. Standards set by the Royal College of Emergency Medicine state that an initial clinical assessment should take place within 15 minutes of a patient's arrival at hospital.

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment ranged from 9 to 12 minutes, which was longer than the overall England median from October 2018 to September 2019.

Trust data showed the the percentage of patients receiving an initial clinical assessment within 15 minutes was:

- June 2019 - 71.50%.
- July 2019 - 72.62%.
- August 2019 - 77.19%.
- September 2019 - 74.02%.
- October 2019 - 72.09%.
- November 2019 - 70.05%.

Crowding in the ED remained a significant risk. Staff told us this and we saw the challenges this presented during our visit. The biggest impact of this related to delayed ambulance handover and delayed initial assessment for both ambulance-borne and self-presenting patients. Some patients waited over an hour to be triaged during our visit. the national standard is to have an initial clinical assessment within 15 minutes.

Patients arriving by ambulance when the ED corridor was full remained in the care of the ambulance service until they were handed over to ED staff inside the department. There was a joint statement for the 'management of patients in the corridor', which had been agreed between the ED and ambulance service. The agreement included a flow chart which indicated all patients would be seen by ED staff within 15 minutes of arrival, reviewed by a clinician within 30 minutes and receive an 'executive' review after 60 minutes of waiting. We were told that after 60 minutes of delay, ambulances could leave, and the patient would become sole responsibility of the ED. However, not all staff were clear who had clinical responsibility for patients waiting for admission to the ED in the outer corridor area or for patients waiting on the back of ambulances.

The handover of patients to the triage nurse in majors worked efficiently until such time that the major's corridor reached capacity (four patients). Thereafter, patients queued in the outer corridor, which was not visible to the triage nurse or nurse in charge. Both corridors were at or nearing capacity for much of our visit and ambulance crews frequently experienced significant delays in offloading their patients. On two occasions, patients were held on ambulances outside the ED, for a period of about 20 minutes, because there was no space in the corridor. There was a nurse present in the outer corridor for much of the time and the hospital ambulance liaison officer (HALO) was present and active in cohorting and monitoring patients but was also frequently moving trollies around in the department to make space. At times, neither was present in the corridor and patients did not have access to call bells to summon assistance. At times, it was difficult to identify who had oversight and accountability for management of this corridor. We saw

the protocol for ambulance offload, but it did not accurately describe the process we saw when the department was in escalation. After the departure of the HALO in the late evening, the lines of communication and responsibility became more confused. It was not clear which ED staff had accountability and oversight of those patients in the outer corridor.

For self-presenting patients, we witnessed a slow process of triage. There was one triage nurse employed, supported by emergency nurse practitioners (ENPs) who were able to see and treat patients. We observed that each triage consultation took between seven and 10 minutes. This process did not keep pace with demand and the staffing levels were not adjusted to accommodate this. To some extent this was mitigated by the fact that receptionists had been trained and had had guidance on red flag symptoms and knew when to alert clinicians if they were concerned about a patient. Reception staff logged walk-in patient's details, and had written guidance on clinical 'red flags', such as chest pain, traumatic injury or signs of a stroke. The guidance informed them when they had to escalate a patient immediately to nursing and medical staff. Reception staff were able to describe when they would escalate patients to clinicians.

The status of the ED was determined by a safety matrix that used information on patient numbers and complexity, ambulance arrivals and staffing levels, to assess if the conditions promoted patient safety. The categories were normal, busy, critical and overwhelmed.

We did not observe this process for children; however, we were told that children would be directed by reception staff to a separate children's waiting room. This could not be observed by either nurses or reception staff and, although equipped with CCTV, this was viewed only by security staff. We also noted that the door to the children's waiting room was propped open all day, so this did not provide a secure environment for children.

We observed the care and treatment of acutely unwell patients in the ED. Staff had access to and complied with appropriate guidance and treatment protocols. The resuscitation area was full most of the time during our inspection, as were the two high dependency cubicles in the major's area. However, staff had good oversight of this and moved patients around accordingly.

Staff in the ED recognised the increased risks associated with patients remaining in the department for considerable lengths of time. In order to reduce the risk, they used the Global Risk Assessment Tool (GRAT) which required nurses to assess and record whether each patient was in an appropriate clinical area, for example, and if they had experienced treatment delays or had prolonged immobilisation. If a risk was present, the GRAT indicated the action staff had to take. Actions included informing the nurse in change and where appropriate, a senior doctor. However, during our inspection, we did not see any GRAT charts in use.

Staff had access to mental health liaison services 24 hours a day, seven days a week. Staff knew how to make an urgent referral and we were told patients were seen promptly. The liaison team was staffed by the local mental health trust and was available from 8am to 10pm. Out of hours, staff contacted the mental health crisis team, to provide assessments. There was a specific risk assessment for patients who described mental health problems. The assessment helped staff to determine whether patients were high, moderate or low risk, which then ensured the patient was given an appropriate level of priority.

Records

Staff mostly kept detailed records of patients' care and treatment which was clear, up-to-date and easily available.

Patients received a comprehensive assessment in line with clinical pathways and protocols. Risk assessments were generally completed accurately, and actions taken to address any concerns. There was a comprehensive nursing document to record patients' ongoing care. This included an hourly safety checklist. We reviewed a sample of seven patient records and found they were not always completed fully or consistently. Hourly observations were not always recorded. Whilst we did not find any examples of unsafe care, record keeping did not provide full assurance that staff were able to identify deteriorating patients and escalate appropriately.

Nursing staffing

Inadequate

Urgent and emergency services

There were enough nursing staff with the right qualifications, skills, training and experience to keep adult patients safe from avoidable harm and to provide the right care.

The ED used a combination of the baseline emergency staffing tool and the National Institute of Health and Care Excellence (NICE) emergency department staffing recommendations, to ensure the department was staffed appropriately. This outlined how many registered nurses were needed to safely staff the department. The tools looked at the acuity of patients and how many were in the department at certain times of the day. As a result, the department had increased its staffing numbers to include a nurse specifically allocated to looking after patients in the corridor. During our inspection, the skill mix of staff was suitable for the needs of the ED and actual staff numbers on duty where the same as planned levels. Senior staff had oversight of the staffing within the department and told us they moved staff around to ensure all areas were safe and that surges in demand were managed.

The nurse rota showed that most shifts were filled, and that the department was fully staffed. This included using bank and agency nurses when necessary, to cover unexpected absences due to sickness, for example. The department had both bank staff and agency staff who were used regularly. Agency nurses completed a local induction and were familiar with the department. Bank staff covered short notice absences and predicted increases in demand. There was a dedicated nurse allocated to looking after up to four patients in the ED corridor. This was staffed 24 hours a day and was provided as an extra member of staff to the ED.

We heard about a recent uplift in nurse staffing which, it is hoped, will reduce the current reliance on temporary nursing staff. Despite current vacancies, we were reassured that that rotas were consistently filled, albeit with support from bank and agency staff. Senior staff were able to adjust staffing levels to meet surges in demand, without challenge. We were pleased to hear about the more structured approach to nurse education, and particularly the work that has been completed to ensure adult-trained nurses are suitably trained to care for sick and injured children.

Medical staffing

Whilst there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care at the time of the inspection, consultant cover in the department did not meet recommended guidelines.

Consultants were in the department from 9am to 10pm weekdays, and from 9am to 7pm on weekends. This did not meet the Royal College of Emergency Medicine (RCEM) minimum standard of 16 hours consultant presence each day. On some weekdays, consultant cover ended at 8.30pm. The department saw less than 16,000 children a year and therefore did not require a consultant with specialist training in paediatric emergency medicine. Consultants and registrars were trained in advanced paediatric life support. We were encouraged that there is work ongoing to increase medical staffing. Despite ongoing shortage of consultant and middle grade doctors, rotas were filled and junior doctors felt supported. We did have concerns however about the number of additional shifts doctors were working to fill gaps in the rota and whether this was sustainable. Lack of communication was a recurring theme. Many patients and relatives were resigned to the wait but expressed frustration that they were not well informed. However, we saw staff taking steps to preserve their dignity as much as they could; they apologized for the wait and the environment they were waiting in and offered them drinks and blankets.

Are urgent and emergency services effective?

(for example, treatment is effective)

Patient outcomes

Unplanned re-attendance rate within seven days

The service had a worse than expected risk of re-attendance compared to the England average. From October 2018 to September 2019 the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average.

Inadequate

Urgent and emergency services

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

Inadequate

Access and flow

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

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

The status of the ED was reported to the bed management team via an electronic system. Bed management meetings took place four times per day and were attended by senior staff from across the hospital, including ED. We were told staff worked together to review capacity and identify ways to improve flow and minimise the impact on patients.

Activity

NHS Trusts are required to monitor and report nationally the percentage of patients who attend ED and get seen, discharged or admitted within four hours of arrival. This is known as the Emergency Access Standard (EAS). The NHS standard requires 95% of patients to spend less than four hours in ED.

Trust data showed that in November 2019, there were for Alexandra Hospital:

- Non admitted, non referred Emergency Access Standard (EAS) performance was 81.23%.
- Non admitted, referred EAS performance was 43.66%.
- Category 4 & 5 (Minor) attendances EAS (%) was 85.21%
- Category 1 to 3 (Major attendances) EAS (%) was 56.83%.

Median time from arrival to treatment (all patients)

Managers monitored waiting times and tried to make sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard and was worse than the England average from October 2018 to September 2019. The median time to treatment ranged from 77 to 91 minutes.

Percentage of patients admitted, transferred or discharged within four hours (major type 1 A&E emergency departments)

Managers and staff tried to make sure patients did not stay longer than they needed to. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From November 2018 to October 2019, the trust failed to meet the standard and performed much worse than the England average.

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

Over the 12 months from November 2018 to October 2019 at the Alexandra Hospital, three 843 patients waited more than 12 hours from the decision to admit until being admitted.

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

From October 2018 to September 2019, the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was reported generally as 0.0%.

Median total time in A&E per patient (all patients)

Inadequate

Urgent and emergency services

From November 2018 to October 2019, the trust's monthly median total time in A&E for all patients was lower than the England average.

Lack of flow in the hospital was an ongoing significant challenge. We attended the 3pm bed meeting, which was well structured and well attended by the right people. At 3pm, it was confirmed that all patients waiting in ED had a plan and this was encouraging but the actual and anticipated bed deficit was concerning. There was discussion about activating escalation beds in the day case unit, but these would not be available until later in the evening. We were told there are no other escalation areas and the hospital does not operate 'boarding' on wards due to safety considerations. We did not discuss this fully but would welcome further information about this to assure us that all possible steps have been taken to share the capacity/crowding risk currently held by the ED. We spoke with the director of operations for urgent care and discussed some of the workstreams ongoing to address patient flow. It is acknowledged there is still much to do to improve early discharges.

The ambulatory emergency care unit was operating effectively, and staff were proactively 'pulling' patients from the emergency department. While the unit was not busy when we visited it, we heard at the 3pm bed meeting that 20 patients had been seen and discharged home that day. The conversion rate, we understand, is low and line with expectations. We heard about plans to extend the operating hours of this department, which will help to relieve pressure on the emergency department.

We heard that there were positive and cooperative relationships with the medical assessment unit; however, we were also told that a significant proportion of the medical take continues to come via the emergency department. This was the case when we visited. We saw acute physicians in the emergency department throughout the day. Staff reported that there remain challenges with regard the prompt review of some surgical patients. We understand that internal professional standards exist, and compliance is being monitored and we will request some further information on this.

Staff were also positive about the frailty team, but it was felt that their 'front door presence' could be increased.

Are urgent and emergency services well-led?

Inadequate

Leadership and culture

Leaders understood and tried to manage the priorities and issues the service faced.

Whilst we were unable to speak at length with many staff, those we did speak with were positive and upbeat. We saw a dedicated and professional team of people, who were passionate about providing the best possible care and treatment, and who were proud of their team and their department. They told us they felt well supported by the local leadership team (the matron was particularly highly regarded and respected) and the rest of the hospital. Pressure in ED was everybody's business.

Relationships with third party providers, the ambulance service and the psychiatric liaison team were reported to be positive. The presence of the HALO during weekdays undoubtedly helped significantly with management of the outer corridor, but there was no consistent HALO presence at night or during weekends.

The psychiatric liaison service was reported to be supportive and reasonably responsive during the day but out of hours, there was little support, meaning that patients with mental health needs remained in the ED overnight awaiting assessment. We understand that there is limited support for Child and Adolescent Mental Health Services (CAMHS) patients and we were told that young people requiring CAMHS input would most likely be transferred to Worcestershire Royal Hospital.

Vision and strategy for this service

The service had a documented vision for what it wanted to achieve but it was not working. Plans were still being developed to ease overcrowding in the department with involvement from staff, patients, and key groups representing the local community.

There was a trust wide plan for improving the flow of patients through the hospital but it was not working. This had included the opening additional beds for general

medicine patients. The reconfiguration of services included moving patients that were being cared for in surge areas and this would enable surge areas to function as normal. The trust had worked with the local Healthwatch regarding care for patients in corridor areas in the department. The service had a vision of what they needed to do to improve flow but it had not been enacted. Trust wide, this included working on patient pathways in ambulatory care and the provision of assessment trolleys in the medical assessment unit for direct admissions (GP expected).

Governance, risk management and quality measurement

The service had a systematic approach to continually monitor the quality of its services. The service monitored activity and performance and used data to identify areas for improvement.

Data relating to performance was clearly displayed in the unit. Staff openly discussed performance and what it meant for patients. Staff knew the main risk areas in the department and the actions needed to keep patient safe from avoidable harm. The service maintained a dashboard of activity which was discussed as part of team and management meetings. Audits of risk assessment in the department were carried out and used to drive improvements.

Culture within the service

Staff and managers across the service promoted a positive culture that supported and valued one and other.

Nurses and doctors said they gave the best care they could to all patients attending the ED However, they told us that the department was sometimes overwhelmed with patients and that there was not always enough staff to carry out all of the required tasks in a timely manner. Doctors told us they needed more doctors in the department to run a safe and effective service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

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

Action the hospital MUST take to improve to:

- The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments and patients are able to call for staff support at all times. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that patients receive medical and specialty reviews in a timely manner. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that consultant cover in the department meets national guidelines. Trainee consultants must not be classed as 'consultants' on the staffing rota. Regulation 12 (c)
- Fully implement the trust wide actions to reduce overcrowding in the department including following escalation procedures and maintain effective oversight of the sickest patients in the ED. 12 (2) (a) (b) (i)

Action the provider SHOULD take to improve

Action the hospital SHOULD take to improve to:

- The trust should ensure that handovers are completed ensuring patient privacy Regulation 10 (2)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. We have imposed conditions on the trust's registration to ensure urgent improvements are made in the timeliness of assessment, care and treatment for patients.