Barking, Havering and Redbridge University Hospitals NHS Trust

Queen's 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 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 Queen's Hospital

Inspected but not rated

We carried out an unannounced focussed inspection of the emergency department (ED) at Queen's Hospital in November 2021 in response to concerning information we had received in relation to the quality of care and safety of patients in this department. At the time of our inspection the department was under adverse pressure.

The ED is open 24 hours a day, seven days a week and sees patients with serious and life-threatening emergencies. There is a separate paediatric emergency department dealing with all attendances under the age of 18 years. Patients present to the department either by walking into the co-located urgent treatment centre and being streamed to ED or arrive by ambulance via a dedicated ambulance-only entrance.

Barking, Havering and Redbridge University Hospital NHS Trust had almost 270,000 patients attending its emergency department in the last 12 months with the majority of these attendances at Queen's Hospital.

Our inspection had a short announcement (around 30 minutes) to enable staff to arrange to meet with us and for us to carry out our work safely and effectively.

At our last inspection in January 2020, we rated the ED as requires improvement overall.

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

- The trust faced challenges with access and flow which meant they could not always ensure patients accessed the emergency department when needed, to receive timely treatment. Performance data showed delays in patients accessing the emergency department both waiting to be seen and receiving treatment, this included delays in ambulance handover. The trust did not have effective oversight of how long walk in patients had been waiting to receive care. Improvements had not been sustained within the emergency department for effective patient flow.
- Patients were not always cared for in the best place for their treatment needs. Patients in the emergency department could not be moved promptly to medical wards due to lack of capacity as patients could not be discharged in a timely way.
- Challenges with access and flow often resulted in demand exceeding the trust determined safe level of occupancy within the department. Leaders at all levels recognised the service did not always have enough staff to manage these regular surges in demand effectively.
- Social distancing was not always possible and we identified lapses in practice around infection prevention and control.
- Pharmacist oversight of medicines management within the department had reduced since the last inspection. Staff did not always review patients' medication in a timely fashion and medication patients carried into the department was not always securely managed.

However:

- Equipment and the premises were visibly clean. Staff understood how to protect patients from abuse.

Our findings

- Staff, while under pressure, worked hard to provide compassionate care to patients and took account of their individual needs.
- Staff felt respected, supported and valued. Leaders were aware of the challenges within the department and actively working to resolve them.

The inspection of Queen's Hospital also formed part of a system review of urgent and emergency care provision in North-East London. The findings of this review relate to the overall system of care provision in this area, and are not all specific to this provider alone. The following details the findings of this system wide review:

A summary of CQC findings on urgent and emergency care services in Northeast London.

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 Northeast London below:

North East London

Provision of urgent and emergency care in Northeast London was supported by services, stakeholders, commissioners and the local authority. The health and care system in this area is complex, made up of a large number of health and social care providers. We did not inspect all providers within the system and did not inspect any GP services.

We undertook these inspections during the COVID-19 pandemic; the pandemic had put significant pressure on health and social care services and the staff working within them. Despite the challenging circumstances, we found examples of staff working in partnership. For example, there was good engagement between service leaders to understand the impact of demand on different services and to discuss opportunities to signpost patients to services under less pressure. However, system wide collaboration was needed to alleviate the pressure and risks to patient safety identified in the emergency department we inspected.

We were told there were capacity issues, especially in primary care, resulting in delays for patients trying to access urgent care or patients being signposted from 111 to acute services. We were told appointments for out of hours GPs were often unavailable. We observed patients queuing to access both the urgent treatment centre and emergency department and were told patients attended these services due to an inability to access their own GP. This put additional demand on the hospital and caused further delays in patients accessing treatment.

In addition, there had been an increase in the number of 111 calls from patients requiring dental treatment and patients reported a local reduction in dental providers accepting new patients.

We identified an opportunity for more effective integration between the 999 and 111 service; the call system for the 999 service was unable to electronically send information to the 111 service if it was decided the caller did not meet the criteria for an ambulance. The caller was asked to redial 111. In contrast, 111 were able to communicate directly with 999 if they felt their caller required an ambulance.

Our findings

We inspected one emergency department in NE London and found that local services did not always work together to reduce attendances or the length of stay in the emergency department. This resulted in situations of overcrowding, compromised infection control and extended waits for treatment which impacted on outcomes for patients. The ambulance service had commenced daily calls with system partners to try and reduce ambulance handover delays and to monitor demand across NE London.

We identified a lack of collaborative working and poor communication between an emergency department and the co-located urgent treatment centre resulting in delays for people accessing services. Different digital operating systems within these services did not promote effective communication or integration between services and were a limiting factor in how services could work collaboratively to deliver safe, effective and timely patient care. These issues resulted in people being sent from the urgent treatment centre to the emergency department without an effective referral mechanism and meant they experiences further delays whilst in another queue to be assessed.

We found examples of delays in discharge from acute medical care impacting on patient flow across urgent and emergency care pathways. This also resulted in delays in handovers from ambulance crews and prolonged waits in the Emergency Department due to the lack of bed capacity. We also found patients in the emergency department for whom a decision to admit had been made; however, they were still waiting in excess of 24 hours before being transferred to a bed on the ward. These delays exposed people to a risk of harm.

We identified a significant number of patients unable to leave hospital to return to their own home or move into community care. This was due to a number of complex reasons including delays in the provision of care packages due to lack of availability, a lack of residential and/or nursing care beds and because of a shortage of social care staff and the impact of vaccination as a condition of deployment. We were told that Local Authorities were working to increase capacity in social care and that they regularly met with system partners to discuss the provision of urgent and emergency care in London; however, the impact on patient flow through urgent and emergency care pathways remained a significant challenge across NE London. Increased collaboration and support from system partners was required to manage the risk being held in the emergency department we inspected.

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. 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. Mandatory safeguarding adults level 2 training was 98.4% and safeguarding adults level 3 training was 96.9% which was above the trust target of 95%.

Most medical staff received training specific for their role on how to recognise and report abuse. Mandatory safeguarding adults level 2 training was 100% but safeguarding adults level 3 training was 92.4% which was below the trust target of 95%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Control measures were not sufficient in all areas to protect patients, staff and others from infection. However, staff kept equipment and the premises visibly clean.

Overcrowding of patients and relatives in the emergency department (ED) meant social distancing could not always be adhered to. There was an increased risk of nosocomial infection where patients were waiting in crowded areas. The inspection team observed the Majors B area, where patients access the ED and are triaged, was a bottleneck with a significant backlog, and this resulted in crowding. There was limited distancing between the patients and ambulance crews who waited with the patients outside the RAFT (Rapid Assessment and First Treatment) area. Individuals were near to each other and unable to follow the two metres social distancing COVID-19 requirements. This was not in line with best practice guidelines set out by the Royal College of Emergency Medicine for Emergency Department Infection Prevention and Control during the Coronavirus Pandemic. However, all patients were required to wear masks, or visors, upon entry into the hospital and we observed this being strictly enforced by the hospital.

The department had a separate smaller Majors strictly for patients who were symptomatic or positive for COVID, called COVID Majors. However, during our inspection we found three symptomatic patients who had tested negative for COVID who remained in COVID Majors. We were told this was due to the risk that they had acquired COVID and could spread it if they had left the COVID pathway. However, these patients were at risk of nosocomial infection while on this pathway despite testing negative. During increased COVID activity the department had previously changed the COVID pathway to proceed through Majors B in order to respond to greater demand from symptomatic and positive patients. Following these concerns being raised with the trust, we were told that two side rooms within COVID majors had been ringfenced for patients awaiting test results. This allowed asymptomatic patients with a negative test result to leave the COVID pathway as they had not been exposed to risk of nosocomial infection.

Urgent and emergency services

The ARC (Ambulance Receiving Centre) did not have handwashing facilities on the first day of inspection. The trust Infection Control team had assessed the previous use of portable handwash basins, these were deemed to present an infection risk and therefore had been removed. This area was staffed by paramedics from the local NHS ambulance trust. Following removal of the temporary sinks the paramedics followed the same infection, prevention and control measure used in ambulances which involved hand wipes to maintain hand hygiene. However, hospital staff attended the ARC to deliver medication and it was not clear how they would wash their hands. We raised this concern with the Trust on the first day of inspection and by the end of the second day a sink had been installed in the area for staff to use.

The trust audited infection control practices quarterly and between October and December 2021 there were some areas where non-compliance was identified. Audits were carried out by a central infection, prevention and control (IPC) team within the trust who had responsibility for auditing all departments within the hospital. Standards checked included environment; hand hygiene, PPE and saving lives; cleaning and decontamination; linen, sharps and waste management; staff practice; and transmissible infections. The accumulated average for IPC across the division was 78% compliance with resuscitation performing worst at 63% compliance.

All areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly, and the service generally performed well for cleanliness. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. During our inspection we observed domestic staff cleaning areas of the department.

Staff followed infection control principles including the use of personal protective equipment (PPE) and hand hygiene. We saw staff wash their hands between patients. There was a full supply of PPE available to them. Staff were seen to be following the national and local guidelines to protect themselves from infection. Staff told us they had received effective training in putting on (donning) and removing (doffing) PPE to prevent the risk of cross infection. Staff were aware of the need to socially distance and remain two metres from each other. However, this was difficult to achieve in the hospital environment.

Staff carried out high-risk procedures which could generate aerosols into the atmosphere (known as AGP) in designated areas using full PPE. However, these procedures took place in the resus area on known COVID-19 positive patients in designated COVID-19 beds, where there was not adequate separation from negative patients. This was not in line with national infection prevention control guidance as the individual treatment areas were not self-contained leading to an increased risk to other staff and patients in that area. Following the inspection, we raised this concern with the trust and action was taken to have two separately ventilated beds within the resuscitation area for COVID patients.

Environment and equipment

During the current pandemic, with the limited footprint available, and with the department routinely operating over capacity, efforts had been made to protect patients and staff, but the design and use of some parts of the premises did not always keep people safe.

The ED had been reconfigured in response to the COVID-19 pandemic to meet national guidance. This had undergone multiple revisions to respond to changing demand for COVID-19 care since March 2020. At the time of inspection, the service was divided into eight areas plus a reception desk which was staffed at all times. These were Majors A, Majors B, COVID Majors, Rapid Assessment and First Treatment (RAFTing), resuscitation, paediatrics, and the Ambulance Receiving Centre (ARC). The changes to the layout in the department had resulted in staff feeling areas within the department, especially the ARC, were more disjointed and that their visibility of patients had been reduced. Following our inspection, the ARC was relocated to cohabit the same space as RAFTing allowing for changes to the exclusion criteria to allow more patients to use the ARC and subsequently more ambulance crews to be released.

Urgent and emergency services

Patients were streamed from the urgent treatment centre (UTC) which meant patients having to walk through the hospital from the UTC to reach the ED. Patients were getting lost moving between the UTC and the ED. The trust had identified this as a concern and introduced volunteers to help direct patients. However, during the inspection we still observed patients getting lost due to the distance between departments resulting in poor patient experience.

High demand in the ED within a limited footprint resulted in overcrowding at peak times in areas as patients waited to be seen. The safe level of occupancy within the emergency department as determined by the trust was 85 patients, however during surges in demand this regularly exceeded 150 patients with as high as 196 patients across the department. The main areas of overcrowding were in Majors B, where all walk-in patients attended, and outside of RAFTing, where ambulance patients waited with crews. Crowding during long waits increased the risk for nosocomial infections as patients were unable to maintain distancing within the footprint of the department. In addition to infection control risks, we found patients were being kept for extended periods on trolleys due to the limited availability of beds and high demand, which exposed them to risk of skin degradation.

The paediatric area was secure and had appropriate facilities for the care of children. The area had relocated during the pandemic, and was a separate unit to the main department, with a separate entrance and its own reception area. There was a large waiting area within the paediatric area which was well equipped and easily visible to staff.

The paediatric area had its own resuscitation rooms which were fully stocked to allow for treatment of children of different ages. The primary paediatric resuscitation room had a small footprint which combined with equipment limited the useable space. Staff told us this was effectively mitigated by limiting involvement in paediatric resuscitations to strictly necessary staff but this risk remained on the paediatric ED risk register.

The ED appeared clean and was kept tidy. Corridors and rooms were well lit and uncluttered. Cupboards we opened were organised and stocked.

Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys, which were sealed with a tamper evident tag. Safety checks were carried out daily.

Assessing and responding to patient risk

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

Some patients had a prolonged wait for appropriate treatment after arriving in the department as they could have already spent time waiting at the on-site UTC. Patients presented to the department via ambulance or through the on-site UTC which was managed by a separate independent provider. Staff at the UTC saw all walk-in patients initially, then streamed and triaged them, and directed them to the hospital's ED if appropriate, where they would be triaged a second time. Triage is the process of determining the priority of patients' treatments based on the severity of their condition.

Waiting times for initial assessment at the UTC were not monitored by the Trust. Standards set by the Royal College of Emergency Medicine states that an initial clinical assessment for triage should take place for all patients within 15 minutes of their arrival. During inspection we spoke with 10 patients who waited over 40 minutes at the UTC and at least another 20 minutes at Majors B.

Urgent and emergency services

All walk in patients were assessed for their risk of COVID-19 on entry to the UTC and prior to their entry to the ED before being directed to the right pathway. All patients were tested on decision to admit. All tests needed to be sent to the in-house laboratory for processing which added some delay to admitting the patient into a bed. However, patient care was not delayed while waiting for the result.

All ambulance patients were taken directly to the RAFTing area for handover and triage. Here a doctor assessed the patient's condition on arrival, ordered any tests, and categorised the patient by severity of presenting complaint, dictating the priority order of seeing the patient in the department. The median time from ambulance arrival to initial assessment was worse than the England median for every month between April 2021 and November 2021. The median time from ambulance arrival to initial assessment for the trust in November was 18 minutes compared to the national median of 10 minutes. Ambulance crews stay with patients while waiting to handover. This reduces the number of ambulances available to respond to calls outside the hospital until handover has been completed.

In an effort to release ambulance crews, an ambulance receiving centre (ARC) had been created for ambulances to offload patients to prior to the patient proceeding through the RAFTing area. The 9 bed ARC had been created collaboratively with the one local NHS ambulance Trust and was staffed by 4 ambulance staff. In the 6 weeks since opening we were told it had released 600 hours of ambulance crew members time from waiting to handover. The ARC was located some distance from the RAFTing area with limited bathroom facilities and in order to ensure patients here remained safe, a strict exclusion criteria was in place. At the time of inspection the ARC could also only be used by the NHS ambulance trust that staffed it and not with any other ambulance service operating within the region. We observed the RAFTing area at 22:00 and found that 14 ambulance crews were queued in the corridor awaiting handover while simultaneously only 2 beds in the ARC were being utilised. Staff in the ARC were observed to be actively seeking to take patients, however limitations including the exclusion criteria meant this could not be done. Staff told us they felt that while the ARC was a good idea, in its current form the positive impact it could have was limited. Following the inspection, the ARC was relocated to cohabit the same space as RAFTing and additional ambulance services agreed to use it allowing for more patients to use the ARC and subsequently more ambulance crews to be released.

The waiting area in Majors B, for patients awaiting emergency triage, transfer to one of the cubicles or the fit to sit area, became crowded during busier times. Clinical staff members physically visited the waiting area at least every 15 minutes to carry out a visual assessment of all patients. During our inspection we observed these checks being carried out. We were assured there was adequate oversight and responsibility of the patients waiting to be seen, however long waits still posed a risk to patient safety. Patients were being seen in priority based upon their clinical need, but not all patients were being seen in a timely manner.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Electronic observations with National Early Warning Score 2 (NEWS2) had been implemented in the ED since August 2021. This facility provided accurate scoring and increased visibility of patient condition with automatic scheduling of observations based on patient condition. Patient condition in respect to NEWS2 score was visible within the department electronic patient record and tracking system which enabled an at a glance view of patient status. This linked with delivery of the ED safety checklist.

Staffing

The service was under pressure to ensure there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Leaders within the service had recognised their ability to respond to increased demand within the emergency department was at risk with current staffing levels. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Urgent and emergency services

The COVID-19 pandemic has brought additional pressure to all hospitals in the country due to staff either becoming infected or being required to self-isolate after contact with a positive person. There was also increased demand as patient numbers surged presenting to emergency departments with higher acuity. Patients told us both during and prior to the inspection that although waits were long within the ED, they knew they were guaranteed to be seen in person before leaving and this was easier than trying to arrange to be seen by a GP.

Nursing staff vacancy rates in the ED for October 2021 were 6% with a turnover rate of 15%. Average sickness rates for the 12 months between November 2020 and October 2021 were 7%.

Medical staff vacancy rates in the ED for October 2021 were 32% with a turnover rate of 12%. Average sickness rates for the 12 months between November 2020 and October 2021 were 3%.

Patient acuity and a sustained increase in patients attending the ED meant that having enough staff to meet the demand had been a challenge and staff told us that they felt they needed more staff to be able to safely deliver care. Assurance of safe staffing in the ED was assessed using professional judgement, activity and flow data and acuity and dependency where applicable. As recommended in the last safe staffing review, a detailed review of ED nurse staffing had been undertaken in recent months as part of a wider departmental staffing review and a business case had been submitted to increase staffing levels due to increases in volume of both activity and departmental layout. The business case included the staffing recommended following a CQC visit in 2020 which had been in place but not added to the funded establishment.

Individual patient acuity and overall department patient needs and status were considered within at senior team huddles (PIT stops) which occurred at least three times each day. These took place alongside regular nurse and medical staff in charge review of patients. These reviews addressed surge, reallocation of staffing and direction of support to areas of need alongside escalation of needs within the trust and wider system. Leaders from the UTC attended these PIT stops to allow for an understanding of demand across both the UTC and ED.

When staffing was not meeting planned levels, the trust would use bank staff or agency staff. All bank and agency staff we spoke with had completed an induction and were familiar with the department. However, we were told that bank and agency staff were in demand at other NHS trusts in the region and there were challenges in relying on temporary staff.

The number of paediatric trained nurses working within the department meant they were compliant with Facing the Future Standards for Children in emergency care settings. This meant the department was always staffed with two registered children's nurses. Data showed staff were up to date with appropriate paediatric intermediate life support.

Records

Digital systems did not allow for the transfer of patient information from the onsite urgent treatment centre.

When patients were triaged from the UTC to the ED, they had their clinical notes up to that point including a set of observations printed off to take with them. This meant staff within the ED had to enter patient information onto a new digital system which duplicated data entry and took up staff time. Information was accompanying patients on paper due to the UTC and ED using two different digital systems that could not communicate patient information with one another. This contributed to an extended patient journey through the urgent care pathway and a poor patient experience.

Urgent and emergency services

Medicines

The service did not always have systems and processes to safely prescribe, administer, record and store medicines.

Pharmacy staff told us that medicines management across the trust had been negatively impacted by the COVID-19 pandemic. The number of medicine governance audits and medicines management walkarounds being carried out had been reduced to minimise teams moving between areas of the hospital with the associated risk of nosocomial infection. We were told that pharmacy staff were still working with ward teams to meet assurances but that these had been difficult due to a combination of workforce challenges and a lack of digital prescribing.

Medicine management issues within the ED were being caused and exacerbated by issues with flow resulting in the long length of stay for high numbers of patients within an inappropriate setting. This resulted in increased risks around missed doses of medication and medicines security.

Staff did not always review each patient's medicines in a timely fashion. This exposed patients to the risk of missed time critical medication such as those for Parkinson's disease and diabetes. Missed time critical medication had been raised as incidents in the past and some learning had been implemented in an effort to address this. Measures introduced included stockpiles of time sensitive medication within ED and virtual training for staff around diabetes medication which had resulted in a reduction in the number of related incidents. However, senior leaders acknowledged that these measures still depended on staff reviewing patients' medication in a timely fashion.

Medication accompanied patients through the busy ED which exposed the risk of medication being lost or mixed up with other patients medication. Where patients attended the ED with their own medication, this was not stored securely by the trust and instead remained the responsibility of the patient.

There was no implemented policy to manage people's own medicine including self-administration. Patients continued to have access to their own medication through the ED which had the potential to result in patients self-administering medication without the knowledge of hospital staff resulting in double dosing.

Medicines administered by the trust were securely stored in keypad locked rooms. Room and fridge temperatures in the ED were monitored, and temperature excursions were reported to the trust pharmacy team. Manual checks were carried out daily by staff, but we saw that fridges in ED had an electronic data logger fitted. Once enabled this would remove the task of daily checks on the wards teams and the pharmacy department would monitor any changes to temps digitally. There was a system in place for when fridge or room temperatures exceeded the recommended temperatures, a red sticker was applied effected medication to bring forward the expiry date by three months.

Is the service caring?

Inspected but not rated

Compassionate care

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

Urgent and emergency services

Staff were discreet and thoughtful when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff introduce themselves and explain who they were and their role. They spoke quietly to patients to try and ensure they maintained a level of patient confidentiality.

We observed staff providing compassionate care where they were able to do so. Staff apologised for keeping patients waiting, despite this being beyond their control. Staff told us they found the extended waits for patients and overcrowding within the department distressing at times.

Patients said staff treated them well and with kindness and that they were happy with the care they received despite their frustrations with the long waits to receive it. Some patients told us they were content to wait as long as necessary in the emergency department (ED) as they understood they would see a doctor eventually.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Forty-two volunteers had been recruited to provide support to patients and support staff in keeping patients comfortable whilst waiting. Volunteers had a dedicated Band 6 nurse who was a point of contact should the volunteers require on top of the coordination by the Volunteering team. Leaders told us that many of the volunteers wanted to work in health care and this was part of the departments approach to attract locals to the trust.

In response to extended waits for treatment in the department, the trust had increased the availability of food and drink to patients to be 24/7. This included two hourly food and drink rounds, hot food being available to request by nurses and a vending machine located in the Majors B area.

Is the service responsive?

Inspected but not rated

Access and flow

The trust faced challenges with access and flow which meant that they could not ensure people were able to access the emergency department when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Patients could not all access the emergency department (ED) in a timely way and the trust faced known challenges with access and flow. Managers and staff worked to try to ensure patients did not stay longer than they needed to, but the demands on the service and challenges with access and flow did not ensure this was consistently managed. The trust had not sustained improvements since the CQC inspection in January 2019 where the trust was told it should:; “continue working to reduce ambulance handover times”; “continue working to improve the flow of patients out of the ED” and “continue working to improve A&E four hour target performance”. Since this inspection, the trust had been supported by NHS external regulators with a goal of improving ED performance although the focus of these had expanded to include the trust response to COVID-19. However, this inspection identified that progress had not been sustained and similar themes continued to impact on patient safety and patient flow.

Urgent and emergency services

Performance data showed delays in patients both accessing the ED and waiting to be seen. There was a risk patients were unable to access care and treatment in a timely way. There was also an additional risk to the system when ambulances were held for long periods of time and were unable to respond to other calls where patients require timely care and treatment.

The Department of Health's standard for ED's is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The trust did not meet the standard and performed worse than the England average. In November 2021, 57.2% of patients spent less than four hours in the ED; the national average was 74%. The trust performance was worse than the national average throughout 2020 and 2021.

The national standard for median time from arrival at the ED to treatment is 60 minutes. The trust did not meet the standard and performed worse than the England average. In October 2021, the median time from arrival at the ED to treatment was 134 minutes; the national average was 78 minutes. The trust performance was worse than the national average throughout 2020 and 2021.

All walk in patients accessed the ED after being seen at the onsite urgent treatment centre (UTC) which was being run by a different provider and was not part of the trust. The UTC used a red and yellow card system at the point of streaming and triage to identify which patients needed to be seen by the ED. Streaming is the assessment and decision by a clinician where patients can receive the most appropriate care and directing them to it.

Urgent patients who were identified at the point of streaming into the UTC were given a red card sending them immediately to the ED. Patients triaged by the UTC and identified as requiring treatment in the ED or from a hospital speciality were given a yellow card and sent to Majors B. All other adult patients were either treated within the UTC or signposted to other services within the community for treatment. Children who needed emergency care were given a blue card directing them to the paediatric ED. Staff in the ED told us they felt that not all patients triaged to attend from the UTC were clinically appropriate and that they could be better treated by either the UTC or other services in the community. During our inspection we observed seven patients being raised by ED staff with the UTC as non-emergency cases that were taken back by the UTC for treatment. However, we were told this was not routinely done due to the negative patient experience of moving back and forth without treatment. Leaders told us this contributed to overcrowding as high demand for treatment within the ED was not being effectively controlled. Upon exploration of this issue we evidenced a disparity in the desired clinical protocol of clinicians working in the ED, versus the currently agreed clinical protocol with the referring UTC. This resulted in frustration for staff in regards to the current clinical streaming model and although discussions with the UTC about this had begun these were still at an early stage at the time of inspection.

All patients who proceeded to the ED from the UTC (red and yellow cards) were triaged a second time in the ED. Standards set by the Royal College of Emergency Medicine states that an initial clinical assessment or triage should take place for all patients within 15 minutes of their arrival. However, digital systems used by the trust and the UTC were not able to communicate patient information, including total time spent waiting for treatment, therefore waiting times to be assessed in the UTC were not being effectively recorded by the trust. This meant patients registering at the ED could have already waited significantly longer. Ten patients told us they had waited over 40 minutes for triage in UTC and over 20 minutes for a second triage in Majors B. Patients and staff told us that this was a point of frustration for patients.

Leaders from the ED and UTC met weekly to discuss performance, pressures and actions to improve services. A joint action plan was in place to monitor progress and assign actions to individuals from either service. Late referrals from the UTC who went on to breach the 4 hour target in ED were raised as incidents and in November 2021 there were 83 patients reported to fit this category. ED leaders told us they felt the streaming process was not always as effective as it

could be and that non-emergency cases that could be treated by non-emergency services still reached the department. A single audit was carried out in August 2021 with a subjective assessment of streaming criteria by an ED clinician and ED manager based on 104 consecutive notes with outcome data. This identified that up to 50% of patients may have been appropriate for UTC review under a streaming model employed at another trust. The results of this audit had been raised with the provider of the UTC and discussions between leaders and clinicians from both services were ongoing about amending the current streaming model to better ensure walk in patients received care in an appropriate setting.

Staff and leaders told us same day emergency care (SDEC) for patients, which is now a mandated pathway for patients and would take patients away from the overcrowded department, was not being used effectively. During the inspection we observed this was the case and the SDEC was not being utilised effectively for its intended purpose. Senior staff told us that this was in part due to its colocation within Majors B.

Patients arriving by ambulance were triaged in the Rapid Assessment and First Treatment (RAFTing) area once they had been registered onto the hospital patient electronic system, unless the patient had to be brought directly to the resuscitation area (resus). At the time of the last inspection we found that there were often periods of overcrowding when ambulance crews were unable to handover the patient and on this inspection we found this was still the case. During these periods, the corridor was used as extra capacity, where ambulance crews could wait with their patients. The trust had been working with the ambulance services in order to improve ambulance handover times and release ambulance crews back onto the road. An Ambulance Receiving Centre (ARC) had been setup in September 2021 with nine bays to accommodate ambulance patients before handover to the ED and a Hospital Ambulance Liaison Officer (HALO) from the local ambulance service had been introduced within the department.

The ARC was permanently staffed by four ambulance staff meaning crews with applicable patients did not have to wait for handover and could return to the road, the local major ambulance NHS trust told us this had saved 600 hours for ambulance crew in the first few weeks of being open. At the time of inspection there was a strict exclusion criteria for patients in place in the ARC and this limited its use. However, following our inspection the ARC had been relocated to cohabit the same space as the RAFTing area allowing for a wider range of patients to await handover including out of region ambulance services. The HALO was onsite from 10am to 10pm seven days a week. Their role was to ensure the smooth offload of patients into the department, to look after ambulance crew welfare, to liaise with the ED about patients waiting with ambulance crews and to help manage the flow of ambulance patients into the ED.

Ambulance handovers were not in line with standards for an ambulance handover (clinical handover and offload) to be reliably completed within 15 minutes of arrival. Performance data showed that on the first day of our inspection, 31.7% of ambulance handovers took 30-60 minutes compared to a national average of 12.6%. On the same day, 14.1% of ambulance handovers took over 60 minutes compared to a national average of 8%. In total there were 477 black breaches in November 2021. A black breach occurs where the time from an ambulance arrival at a hospital to the patient being formally handed over to the trust was longer than 60 minutes. At 21:00 on the first day of inspection we observed 14 ambulance patients waiting in corridors for handover with a further three patients in the ARC. Ambulance staff we spoke with during inspection told us that this ED was routinely extremely busy with long waiting times. This meant patients did not receive the treatment they needed in a timely way.

The wider hospital flow was impacting on the ED. In November 2021, 680 patients waited more than 12 hours from the decision to admit until being admitted compared to the time of the last CQC inspection in December 2019, when 12 patients had waited more than 12 hours. At the time of our inspection some patients had been waiting more than 48 hours for admission to the hospital. In order to manage these long delays in admission safely, Majors A was effectively functioning as an inpatient ward. However, this in turn reduced capacity within the ED to deal with emergency cases contributing to issues with patient flow out of the hospital.

Urgent and emergency services

Piloting and the development of a Queens Frailty unit (QFU) had taken place following the success of this model at King George's Hospital. This unit redirects patients over the age of 75 to a specialist Frailty unit in order to reduce overcrowding in QH ED department and provide a better patient experience. This pilot was originally set to end in November 2021 but had been extended through to March 2022. During the initial pilot period one third of over 75 patients were redirected from the ED and there was an increase of 40% in the number of over 75 patients being treated within four hours. However, leaders acknowledged that the effectiveness of the frailty unit was dependent on flow through the wider hospital and into the community. During times when flow was poor and the frailty unit was full, patients over 75 could not use this pathway so had to remain within the ED.

There were systems in place to manage the flow of patients through the ED to discharge or admission to the hospital. The team could see on the IT system the length of time patients had been in the ED as well as an overview of bed availability and flow of patients coming into the ED which was discussed at regular bed meetings through the day along with staffing numbers. However, despite this oversight, delays in admission, transfer or discharge continued to be caused by the combination of significant numbers of patients arriving in the department and, poor flow through and out of the hospital. There was poor flow within other specialties of the hospital as well as a lack of available care in the community for patients to be discharged to.

For acute trusts, NHS England's operational pressures escalation levels (OPEL) had been nationally defined as being levels one to four, with four being the highest level of operational pressure. This had been adjusted by the trust and detailed how the trust identified and responded to pressures within its system fairly, as well as at times of extraordinary pressure. This framework relates to adult beds. Each day, meetings took place at 10:00am and 15:00pm to review the flow of patients through the hospital and these were attended virtually by bed managers and department nurses in charge. Senior leadership had also defined its own OPEL system for use specifically within the ED to feedback pressure on the ED up to trustwide level. However, despite the ED regularly running with double the safe level of occupancy, as determined by the trust, the OPEL level for the trust had not exceeded level three in the past year. When the department was under severe pressure as it was during our inspection, decisions made to help the department did not visibly translate to a reduction in pressure on staff in the department. This meant the risk of patient flow remained mainly within the ED.

Is the service well-led?

Inspected but not rated

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.

In July 2021 the trust executive team agreed to restructure the Acute and Critical Care division in response to performance challenges, creating the division of Emergency Medicine. Aligned to this, a Medical Improvement Director and a Nursing Improvement Director were appointed, which established a divisional triumvirate with the Divisional Manager. An immediate priority for the new division had been to develop an improvement programme, working closely with clinical teams to formulate priorities that will support improvements in quality, performance and experience. We were told that workforce continues to be the cornerstone of this approach – ensuring the emergency department (ED) has the right people, with the right skills, receiving the right support to deliver high quality emergency care.

Urgent and emergency services

Staff spoke highly of local and divisional leaders within the service. They described them as approachable and supportive. Staff told us leaders at all levels recognised the difficulties facing staff and were actively working to address them.

There was both an Emergency Medicine divisional triumvirate for the trust and local triumvirates for the ED's within the trust. This consisted of three triumvirates with a clinical lead, lead nurse or matron, and a specialty or service manager for Queen's Hospital emergency department, King George's Hospital emergency department, and the paediatric emergency department. The divisional triumvirate consisted of a nurse director, medical director and a divisional manager.

During our inspection we noticed senior staff were visible within the department and staff told us this was commonplace. Leaders we spoke with understood the challenges with flow through the department and were able to identify actions required to tackle them. The managers acknowledged the department was on a journey of improvement and the past year of the pandemic had delayed some of their planned actions.

Executive responsibility for the ED within the trust usually lay with the Chief Operating Officer, however this post was not substantively filled at the time of inspection and was instead being covered by another member of the executive team. During our inspection, members of the trust-wide senior leadership team we spoke with displayed knowledge of the challenges facing the ED in the short, medium and long term, and were able to identify actions required to tackle them. We found evidence that discussions routinely took place at board level around the challenges facing the ED.

Staff told us that they felt supported by the leadership within the service and that issues they raised were escalated appropriately. Most staff told us that they felt the service was supported by the trust-wide senior leadership team and that they were visible. Leaders within the service echoed these comments from staff and pointed to recently approved business cases to increase the workforce across the ED as evidence of the senior leadership team's recognition of challenges and a willingness to invest within the service to address them.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The ED staff had been resilient in their response to the ongoing COVID-19 pandemic. However, staff had found their situation challenging and described being tired.

The trust had invested in the wellbeing of their staff, especially in response to the sustained pressure staff continued to face due to the pandemic. There was a recognition that the wellbeing and morale of staff was impacted over the past year, however we found staff displayed resilience and hope despite these challenges. Senior leadership told us they recognised the pivotal role staff resilience had played in maintaining the urgent and emergency care system despite the tremendous pressure it was under.

Staff were positive about working within the service and praised the teamwork. Staff felt there was good support from senior members of staff and that they were advocated for by local leaders.

Urgent and emergency services

In April 2021 the trust hosted a 'Thank You Week' to thank staff for their service during the pandemic. This week focussed on staff wellbeing including free massages and animal therapy sessions. The week culminated with all staff receiving an extra day of annual leave the trust labelled a 'thank you day' alongside an experience voucher. Staff told us this initiative had been popular and had helped to improve morale following a pressured winter which had included a challenging wave of the COVID-19 pandemic. Longer term initiatives included access to free counselling sessions for staff.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, these actions were not all successful due to the pressure on the service. They had plans to cope with unexpected events but were restricted by the demands on the service.

There were assurance systems used to monitor risks and these were regularly reviewed and improved. Risk registers were used in each department, and there were further risk registers at divisional and trust level to oversee, monitor and review risks. The risks recorded on the registers reflected the concerns staff and managers told us about. The department had a local risk register which was reviewed regularly.

The department risk register included concerns about nosocomial infection, the environment and crowding in the department. Some of these were escalated to the corporate risk register. These reflected the risks we identified during inspection.

The trust used a board assurance framework to provide information about severe and very likely risks. These included risks related to COVID-19.

Clinical and internal audits were carried out within the ED. These included audits directed at monitoring flow such as the fit to fly audit and Majors waiting room audit. However, there was limited improvement based on the results of these audits.

Leaders had identified staffing to meet demand as an issue across the ED. Business cases for Queen's Hospital emergency department, King George's Hospital emergency department and the paediatric emergency department had been approved following our inspection. The purpose of these business cases at Queen's Hospital was to improve the Rapid Assessment and Treatment facility and increase permanent posts to the paediatric ED to effectively manage attendance surges. While additional posts are being permanently recruited to, they are being filled with Trust staff bank and agency provision. This workforce plan derived from clinical professional judgement review (Workforce Safeguards 2018) with reference to the RCEM and RCN guidance on safe staffing.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should work with system partners to improve patient flow through the urgent emergency care pathway.
- The trust should ensure that there is sustained improvement to A&E four hour target performance.
- The trust should ensure that there is a sustained reduction in ambulance handover times.
- The trust should ensure that there is sustained improvement to the flow of patients out of the emergency department.

Urgent and emergency services

- The trust should improve oversight of time to triage of patients arriving in the emergency department through the urgent treatment centre.
- The trust should ensure that infection protection control processes are adhered to at all times.
- The trust should ensure medicines are managed safely within the emergency department.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, a national professional adviser with expertise in urgent and emergency care, an emergency department nurse specialist advisor, a CQC inspection manager, a CQC assistant inspector and a clinical fellow for medicine. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.