

Kettering General Hospital

Quality Report

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

Ratings

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at Kettering General Hospital on 3 February 2020, in response to concerning information we had received in relation to care of patients in this department.

We did not inspect any other core service or wards at this hospital, however we did visit the winter pressure operations centre to discuss patient flow from the emergency department.

During this inspection we inspected using our focused inspection methodology. Because we issued requirement notices, we opted to rate the safe, responsive and well-led domains as requires improvement respectively.

Our high level findings were:

- The design, maintenance, and use of facilities and premises did not always meet patients' needs.
- Risks to patients were not always assessed appropriately. For example, patients that self-presented to the department did not always receive a timely initial assessment or observations. Nursing risk assessments and safety checklists were not routinely completed.
- There were not always enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- There were enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Patients could not always access care and treatment in a timely way.

However;

- The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, the system wide strategy had not delivered the anticipated outcomes.
- Leaders operated a governance process which considered departmental risks, incidents and quality outcomes. However, the process continued to not be fully embedded. There was poor representation at mortality and morbidity meetings which meant there was the potential for missed learning opportunities which could be used to improve patient care.

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

Importantly, the trust must:

- Ensure all patients who present to the emergency department have appropriate risk assessments completed in a timely way to safeguard patients from the risk of harm.
- Ensure patients can access care and treatment in a timely way and in a suitable environment. This should include, but is not limited to the management of patients with mental health needs.
- Ensure the privacy and dignity of patients is maintained at all times.
- Ensure there are sufficient numbers of staff deployed at all times to meet the needs of patients.

In addition the trust should:

- Continue to work to address delays in patients being seen by specialty teams.
- Progress works to improve the environment in which children and young people are seen and treated.

Summary of findings

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to Kettering General Hospital

The emergency department (ED) at Kettering General Hospital provides a 24 hour, seven day a week service for a population of approximately 320,000 people across North Northamptonshire and South Leicestershire.

The main ED consists of 20 bays for patients within majors which were separated into two areas, one with 13 bays (majors one) and one with seven (majors two); nine treatment areas for patients within minors, resuscitation spaces for up to five patients and six areas in the emergency decision unit (EDU). The department has six ambulance streaming spaces and an additional two chairs available in the EDU for the assessment of patients.

The department had it's own children's emergency department (CED) with a separate waiting area, three cubicles and an assessment area.

Patients present to the department either by walking in to the reception area or arriving by ambulance through a dedicated ambulance-only entrance. Patients who

transport themselves to the department report to the reception area where they are assessed and streamed to either the minor's, majors, resuscitation or see and treat pathway.

Between September 2018 and August 2019, the emergency department facilitated approximately 95,000 attendances. This was an increase of almost 8% when compared to September 2017 to August 2018. The department facilitated 18,500 child attendances between September 2018 and August 2019.

The department receives approximately 30,000 ambulances annually. The trust has seen a 7% increase in the number of ambulances arriving to the ED year on year.

We last carried out a comprehensive inspection of the service in February 2019. The service was rated requires improvement for the safe, effective, responsive and well-led domains. The service was rated good for caring. The service was rated as requires improvement overall.

Our inspection team

Our inspection team included a CQC inspector and two specialist advisor's who both had a background working as consultants in an urgent and emergency care setting. One specialist advisor was also the national professional advisor for urgent and emergency care.

The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection for the Midlands region.


How we carried out this inspection

This was a focused unannounced inspection of the emergency department at Kettering General Hospital on 3 February 2020.

We did not inspect the whole core service therefore we have not reported against or rated the effective domain. We did not inspect any other core service or wards at this hospital.

During this inspection we inspected using our focused inspection methodology. Although we did not consider all key lines of enquiry, we have issued a range of requirement notices and therefore rated the safe, responsive and well-led domains as requires improvement.

Urgent and emergency services

Safe	Requires improvement 
Responsive	Requires improvement 
Well-led	Requires improvement 

Are urgent and emergency services safe?

Requires improvement 

Environment and equipment

The design, maintenance, and use of facilities and premises did not always meet patients' needs.

We had previously reported the children's emergency department was no longer fit for purpose due to the limited space to accommodate the increasing number of attendances. Whilst this remained the case at this inspection, the trust had developed plans to increase the overall footprint of the children's emergency department, as a medium term strategy, prior to the wider redevelopment of emergency care services at Kettering General hospital which were anticipated to open in 2024. Building works to create the larger children's emergency department was due to commence in April 2020. The trust further reported having developed a children's project charter which detailed the scope of the rebuilding works; the anticipated project completion date was estimated to be July 2020.

The main emergency department consists of 20 majors bays divided in to two clinical areas; "Majors one" and "Majors two". "Majors two" was a seven bedded space and was reserved for use at times of escalation only. The area was closed during the day on 3 Feb 2020. There were six ambulance clinical assessment and treatment trolleys. The ED operated a "see and treat" service operating from 8am to midnight daily and was staffed by middle grade or associate specialist doctors. There was a small (2 room) minor injury service. There was no designated "Fit to Sit" zone so mobile or sub-acute "Majors" cases were managed in minor treatment rooms, cubicles or reverse queued back to the waiting room.

On our arrival, there were 76 patients in the department. Nine patients had agreed decision to be admitted recorded in their notes and were waiting to be transferred to an inpatient bed. There had been 121 attendances since midnight, 47 of which had been via ambulance. The five bedded resuscitation area was at full capacity. "Majors one" was operating at full capacity with 13 patients. The ambulance streaming area was also full with six patients plus an additional patient queuing in the corridor. The minor's treatment rooms were also all full, and there were 28 patients in the waiting room. The emergency decision unit was also full with six patients.

As the day progressed, the department became increasingly busier. At 17:30 there were 85 patients in the department, "Majors one" and the resuscitation area remained full. There remained nine patients with agreed decision to be admitted. There were three spaces available in the emergency decision unit. There were 44 patients were in the waiting room, and five patients who had arrived by ambulance were being held in the corridor. By 18:45, the number of patients held in the corridor had increased to ten due to a lack of capacity in the department for those patients to be handed over. Despite the increasing numbers of patients presenting to the department, there were insufficient numbers of nursing staff to enable "Majors two" to be opened. To ensure patients remained safe, ED consultants and nursing staff were assessing all new patients who arrived by ambulance, whilst they remained in the corridor. Nursing staff were observed undertaking physical observations. Doctors were asking patients and relatives about previous medical histories and presenting complaints, which was audible to other patients in the ambulance queue.

A "Getting it Right First Time" review of emergency services was carried out in January 2020. This review suggested that, in order to meet the needs of the local population, and to manage the number of attendances to the ED annually, the trust required a minimum of 18

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major's cubicles to operate effectively. We discussed this with the trust executive team following the inspection and we considered using our regulatory powers to drive change. However, the trust provided a robust and rational response detailing the actions they would take to address capacity issues in the department. This included opening the "Majors two" area so it was operational at all times, and not just during times of escalation.

The department had a designated room used for seeing patients who required a mental health assessment but there were three patients in the department who all had complex mental health needs. ED staff had referred the patients to the relevant mental health service however there were delays, due to a lack of specialist mental health beds in the region, in transferring those patients out of the ED. This resulted in patients being managed in clinical rooms which were not appropriate. For example, one patient who had suicidal tendencies was managed in a minor's treatment room. This room contained multiple ligature points which posed a potential risk to patients with suicidal tendencies. We raised this with nursing staff who reported the patient was supervised by a relative and regular welfare checks were being carried out by nursing staff. Nursing documentation was of a poor quality and so there was no contemporaneous records to reflect these checks were being completed. We observed the patient leaving the room on occasions, wandering the corridor. This created opportunities for the patient to leave the department, or to access an unsupervised area such as a toilet for example. Although the patient was not formally detained under any section of the Mental Health Act 1983, and so was free to leave, poor department design and limited line of sight meant medium or high risk patients had opportunities to succumb to suicidal thoughts or to cause self harm, without being noticed by staff. This was recognised as a potential area of risk by the divisional team and was included on the local risk register. However, our observations from the inspection of 3 February 2020 would suggest the mitigations and actions being taken to manage the risk associated with the management of mental health patients, were not robust and therefore warrants further consideration. Whilst all patients presenting with mental health complaints were risk assessed and triaged as low, medium or high risk, existing trust protocols did not permit children or young people from being managed in the major's area of the

department. The trust reported that whilst there were some mitigations in place for this particular patient, including the presence of family members, they acknowledged that within the new children's project, an observation area for children and young people with mental health concerns was to be developed as existing arrangements were not appropriate. In addition, the trust had requested the newly appointed head of safeguarding who had a background in mental healthcare, to undertake a "Fresh-eyes" assessment of the pathway and processes to establish areas for improvement.

There was appropriate emergency equipment in the clinic areas such as resuscitation equipment. Checklists confirmed emergency equipment was checked daily. We checked a range of consumable items from the resuscitation equipment and noted all items were sterile and in-date.

There were systems to ensure clinical waste, such as sharps, was appropriately disposed of. Clinical waste was correctly segregated, stored, labelled and disposed of regularly.

We checked a sample of sharps bins and found all to be assembled correctly, dated, signed and were not over full. Sharps containers were stored at an appropriate height to help prevent children from placing their hands near to, or in the container itself.

Assessing and responding to patient risk

Risks to patients were not always assessed appropriately. For example, patients that self-presented to the department did not always receive a timely initial assessment or observations. Nursing risk assessments and safety checklists were not routinely completed.

We had previously found that patients who self-presented to the emergency department did not always receive a timely initial assessment. At this inspection, we found some improvements had been made in terms of the patient pathway. Self-presenting patients were now initially required to queue to be seen by a streaming nurse. This initial step of the process was carried out in a private room located in the waiting room of the emergency department. A senior nurse undertook a rapid initial assessment of the patient, and if clinically indicated, such as when a patient appeared acutely unwell, a set of observations would be taken to aid in the

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completion of a national early warning score. The streaming nurse then gave the patient an assessment sheet which informed the reception staff which clinical pathway the patient required. We observed good examples of when acutely unwell patients were prioritised and escorted direct to the resuscitation area so rapid treatment could be provided. The signage of this new pathway required improvement as we noted on three occasions, when patients had initially queued to book in with the receptionist, they were advised they needed to see the streaming nurse first, resulting in increased waits for patients. We also noted a lack of seating for patients waiting to be seen by the streaming nurse, resulting in some frail elderly patients having to stand for a period of time.

Where patients were streamed to the "Minors" pathway, a triage nurse or senior health support worker would call patients through in time order, to enable them to complete an initial assessment of the patient, and where necessary, complete initial tests such as blood tests or an electrocardiogram for example. Depending on the outcome of the triage assessment, patients were either asked to wait back in the waiting room until a doctor or advanced care practitioner was available to assess the patient, or patients were referred to other clinical pathways including the same day emergency care service which had opened in 2019. Patients who triggered high on the national early warning scoring system had a yellow "Priority" sticker placed on their clinical notes, highlighting that those patients should be given priority by the medical team over other patients in the minors area. This system was observed to be working well during the inspection.

Children up to the age of 18 were seen in the children's emergency department(ED). Walk in patients came through the main waiting room and were also initially seen by the streaming nurse. If a child was seriously ill then this would be escalated to the children's team. If a child was considered to be stable, they were asked to register with reception before being directed to the children's emergency department where they would the wait in a designated area. Children were then triaged by a registered children's nurse before being asked to wait to be seen by a doctor.

The children's ED consisted of four treatment spaces and a small waiting room. During the inspection concerns

were raised that when the department was busy, there was a long wait to be triaged. This was in part because there was no designated triage room, nor was there a designated children's triage nurse. We observed that at approximately 15:45 there were ten children waiting to be seen in the children's ED. The longest wait was 56 minutes. Three patients had a fever, two with head injuries, one bronchiolitis, one with a chest infection and three with minor illness and injuries. Patients were seen in priority order and we observed four children waiting in the corridor to be seen because the children's ED was not big enough to accommodate these children. The corridor was an open corridor, was not secured for just children and there was no direct visibility of the children's nurses. We also observed doctors taking children to be seen in the adult minors area next to the children's ED due to limited capacity. This was contrary to national standards, specifically those detailed in the Royal College of Paediatrics and Child Health Facing the Future Standards. As we have reported, the trust acknowledged the children's area was not of sufficient size and had therefore committed to increasing the footprint of the department to improve the experience for patients.

Median time from arrival to initial assessment (emergency ambulances only)

The median time from arrival to initial assessment was worse than the overall England median in every month over the 12 month period from December 2018 to November 2019.

The key safety indicator in winter pressures, the 60-min handover delay indicator, indicates that patients arriving by ambulance may be exposed to more safety risk at this trust than other trusts in England. The trust's handover delays were worse than the England average between 30 December 2019 and 12 January 2020, with 307 ambulances (23.2% of arrivals) delayed for more than 60 minutes. We initially wrote to the trust on 10 January 2020 to ask for additional information, including details of the actions being taken by the trust to resolve departmental overcrowding and flow challenges.

For the time period 6 January to 19 January 2020, 13.7% of ambulance arrivals were delayed by more than 60 minutes, which was only just below the threshold to be significantly worse than the England average. However, the trust was significantly worse than expected for ambulance handovers delayed by 30-60 minutes over this

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same time period with 29.2% of ambulances delayed. The trust acknowledged the challenges associated with ambulance handover delays and reported performance to board committees each month. The trust had already undertaken some focused reviews of ambulance handover delays and had identified themes associated with out-of-hours performance; batching of conveyances and reduced bed capacity. The trust reported they continued to liaise with the local NHS ambulance trust, as well as the subject being an feature of the regional chief operating officers network discussions.

The combination of high bed occupancy (99-102%), increasing pressures from stranded patients (7 and 14-day), and a sharp rise in delayed transfers of care potentially contributed to challenges in the ED, in that staff may not have always been able to admit ill patients in a timely, safe way. Further, risks within the department were increased due to poor operational flow, resulting in staff facing challenges with assessing patients in appropriate clinical areas. We noted one patient's wounds could not be fully assessed in the emergency department because of a lack of capacity in the ED. Medical staff had included in the patient's plan for the wound to be reviewed once the patient had been admitted to the ward. Although unlikely, there was a risk that a failure to review the patients wound in the ED meant medical staff may have missed more serious conditions..

Following the inspection, the trust reported 130 patients (26% of the total hospital bedstock) was occupied by super stranded patients. Super stranded patients are described as patients who have been medically optimised and ready for discharge, but remain in an acute hospital bed for more than 21 days. Super stranded patients are often patients who require on-going packages of care, but who do not require acute hospital care. The trust reported on-going engagement with local commissioners to reduce the number of stranded patients to ensure optimal flow for patients accessing the non-elective, emergency care pathway.

Patients who arrived by ambulance were assessed immediately by the nurse in charge and taken into the ambulance streaming area, if capacity allowed. Patients would then see a nurse and have a full initial assessment. A doctor was always present in this area and we saw they undertook patient assessments alongside the nurse. If

any urgent tests were needed, for example, blood tests or electrocardiograms (ECG), they would be done at this stage. We also noted examples when patients at risk of sepsis received initial treatment whilst in the ambulance streaming area. As the day progressed there were increasing delays in patients being handed over from ambulance staff to ED staff. In part, this was compounded by capacity challenges in the ED and an inability to open the escalation area due to staffing challenges. We observed the nurse-in-charge and ED consultants assessing newly arriving patients, however, increased surge activity meant the average handover time increased to 43 minutes at 18:55, with an average ambulance turnaround time of 77.58 minutes.

National early warning scores (NEWS2) were used to assess the seriousness of a patient's condition. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, temperature, heart rate and respiration's were recorded and contributed to a total score. Once a certain score was reached, a clear escalation of treatment was commenced. We reviewed 18 charts that had patients' vital signs recorded on them. The patient's NEWS2 scores and initial observations had been recorded and calculated correctly. There were, however discrepancies, in part due to the poor quality of nursing notes, as to when patients were escalated to either the nurse-in-charge or to a doctor, when a patients NEWS2 score was elevated. For example, one patient had an initial score of one. The local escalation protocol required the nurse-in-charge to be informed and frequency of observations were to be agreed; there was no record of the patient having been escalated, and no frequency of observations recorded. There was also variation in the frequency with which observations were undertaken. One patient had remained in the department for twelve hours and had only had two sets of vital signs recorded. This was despite the patient presenting with acute abdominal pain for which surgical involvement had been requested.

We did note that patients being managed in the minors area had their latest NEWS2 score written on a whiteboard. This gave nursing and medical staff a visual alert as to the patient's condition and level of risk within the clinical area.

There was a patient safety checklist aimed at reminding nursing staff to undertake hourly safety checks of all

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patients in the major treatment area. The list included a variety of checks, which included but were not limited to; vital signs measured, identification wristband on patient, suspected sepsis (infection) screening, blood tests and pain score. This document had initially been introduced in December 2018 by the new senior leadership team. However, as was reported in our 2019 inspection report, not all patients had one completed in a timely manner, or not completed at all during their time spent in the department. We raised this with the executive team who acknowledged further work was necessary to ensure the safety checklist was completed consistently. The trust reported the head of nursing had been released from all managerial duties to help focus on addressing the fundamental nursing activities in the emergency department.

Prior to the inspection we reviewed all clinical incidents reported in the emergency department to the National Reporting and Learning System (NRLS) between July 2019 and January 2020. NRLS is the national patient safety database, established in 2003, to capture all clinical incidents, no matter the level of harm caused, to help the NHS to learn from incidents. We noted ten incidents had been reported during that time in which other departments (such as medical or surgical wards) had identified patients had been admitted with skin pressure damage. This was despite ED nursing records stating no pressure ulcers had been identified on arrival to the ED. We could not fully ascertain whether pressure damage had already been present when patients arrived to the department, and had simply been missed by the nursing team undertaking the initial assessment, or whether pressure damage had been caused whilst patients remained in the ED for extended periods of time, being managed on trolleys.

We reviewed the care records for four elderly patients who had been in the department for more than four hours. One elderly patient had been admitted following a fall at their home resulting in a fracture to their femur. The patient had been in the emergency department for six hours. There had been no falls risk assessment completed for the patient despite their presenting complaint having occurred as a result of falling, therefore suggesting the patient may have been an increased risk of further falls. A skin assessment had been partially completed however there was no recorded actions taken to mitigate against the identified risks. The patient had

remained on a trolley for the duration of their stay in the ED with no supplementary pressure relieving devices used. A second patient had been found on the floor at their home, two days after they initially fell. A review of the patient's nursing records confirmed neither a falls risk assessment or skin assessment had been completed. The patient had remained on a trolley for approximately six hours. A further review of the patient's medical records indicated the patient had a chronic condition which predisposed the patient to peripheral vascular disease, and therefore increased risk of tissue damage. The patient also had an existing leg ulcer, suggesting the patient had compromised skin integrity, and therefore was at increased risk of further skin damage.

We raised these concerns with the executive team. They reported the existing design of the majors area had meant portering staff were finding it increasingly difficult transporting the larger hospital in-patient beds due to a steep ramp from the main ED to "Majors one". Attempts had been made to source equipment to help aid movement of beds but this had not been possible. A decision had therefore been made for all patients in "Majors one" to be managed on trolleys with mattresses designed to more evenly distribute a patient's weight, and therefore reduce the risk of pressure damage. Staff also reported having access to additional equipment including air mattresses which could be placed on trolleys. However, these were not always being used, as was identified during the inspection on 3 February 2020. One reported incident also made reference to a lack of air mattresses in the department despite a patient being identified as being at high risk of pressure damage.

We noted risk 2577 on the divisional risk register made reference to a lack of suitable equipment in the ED, which included but was not limited to air mattresses. Actions from the risk register included local ED staff undertaking a review to ensure they were aware of what equipment they needed in order for the ED to run effectively. Poor record keeping and variation in nursing practice meant the trust board could not be assured risks associated with hospital acquired pressure damage was always being mitigated against, despite there being processes and systems in place. The trust executive team acknowledged the concerns and to address on-going challenges, had released the head of nursing from their managerial duties to help focus on, and tackle both patient flow challenges and improve care standards in the ED. Following the

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inspection the trust also reported they had been working to develop a quality based ED specific ward accreditation programme. Its intention was to help standardise patient level risk assessments and would form a part of the trust-wide "Perfect ward" assessment.

Nurse staffing

There were not always enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

At the time of the inspection, 15 nurses had initially been deployed to support the emergency department; during the day, there was an unplanned reduction to 14 nurses for unavoidable reasons. Nursing staff were deployed across each of the clinical areas and were further supported by health support workers and advanced care practitioners. Emergency nurse practitioners were utilised to deliver the minor injuries service. There were dedicated children's nurses to oversee the children's emergency department which matched national standards.

The trust reported no nurse vacancies in the emergency department, at the time of the inspection. Grades two through seven were fully recruited to, with some bands over-established. The department was in the process of completing a baseline emergency staffing tool (BEST) assessment to determine the future needs of the department. In considering the outputs from the recent GIRFT review, which recommended the department operated 18 major's cubicles, and also in light of the increased waiting times, ambulance handover delays and other waiting time metrics, we explored with the executive team, the basis on which the nursing establishment was based. This was due to the fact that despite demand outstripping capacity on the day of the inspection, a lack of staffing had been attributed to senior staff not opening "Majors two" to help alleviate pressures in the department.

The trust reported that existing establishments had been based on all areas of the ED being open. However, the trust acknowledged that recruitment challenges and changes to care pathways had resulted in "Majors two" only being opened during times of escalation which suggested some contradiction with the GIRFT review, and

also did not match with the 8% increase in activity the trust had seen with regards to ED attendances during the preceding twelve months. This was recognised as a risk by the local team, with an entry on the divisional risk register capturing the fact "Majors two" was only opened during times of escalation. The trust subsequently reported a revised nursing establishment which included an increase of 6.2 whole time equivalent band six posts; 12.09 band five posts; and 19.47 band two posts. On the day of the inspection the trust reported there had been agreed plans for majors two to be opened however acuity and dependency challenges across the trust had meant it was not possible to release the necessary staff to enact this.

In response to our initial feedback, the trust had taken decisive action to ensure "Majors two" remained open twenty four hours a day, seven days a week to aid in the transfer of patients in the minor's pathway to more appropriate clinical settings. Following the inspection the trust reported they were likely to recruit to all posts within the ED establishment should the current recruitment trajectory remain on track. We will continue to monitor this as part of our routine regulatory function.

Regular safety huddles in the ED were observed taking place. Two hourly safety checks were completed by the nurse in charge. This resulted in nursing staff being redeployed to those areas in the emergency department which carried the highest level of risk. For example, due to the increasing number of patients waiting to be seen in the "Minors" pathway, a nurse was moved from the emergency decision unit to support colleagues in minors.

Medical staffing

There were enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

There were eight whole time equivalent consultants, who provided cover in the department from 08:00 to 24:00 Monday to Friday and 08:00 to 17:00 department cover at weekends. Consultants were then on-call thereafter. An additional two consultants were employed, however, both were on long-term sabbaticals and therefore did not form part of the operational rota. Funding had been made available to increase the number of consultants to

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12. The trust further reported a business case was being developed for an additional four consultants to be appointed, for which the trust was supportive of. At the time of the inspection, there was no operational consultant who specialised in paediatric emergency medicine.

The department employed 15 middle grade doctors. Overnight, at least one senior doctor (specialist trainee grade four or above) was rostered which was consistent with Royal College of Emergency Medicine standards. There was evidence middle grade doctors had completed advanced trauma life support and advanced life support training. However, not all middle grade doctors had completed advanced paediatric life support training. This meant that in the event a critically ill child presented out of hours, the children's inpatient registrar was fast-bleeped to manage the child. This was recognised as a risk by the divisional team and was included in the local risk register. Additional funding had been sourced and secured to ensure staff could attend specialist courses with a focus being to ensure nursing staff were trained in the first instance. Mitigations also included the trust operating a children's resuscitation team 24 hours a day who could attend any part of the hospital.

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

Requires improvement 

Access and flow

Patients could not always access care and treatment in a timely way.

Front line staff reported they were on operational pressure escalation level (OPEL) two at the time of the inspection. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to

meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care.

The emergency department (ED) used a nurse-led approach to streaming and triaging patients. After being seen by a streaming nurse in a private room, patients were then asked to register at the reception, before a senior nurse or health support worker would assess patients within 15 minutes of arrival. Where there were challenges in delivering against the 15 minute standard, additional resource was directed to the triage area to help address backlogs. This was observed to happen during the inspection.

Following a review by the streaming nurse, patients could be directed to one of five clinical pathways: minor injuries; see and treat (this dealt with minor ailments which could ordinarily be managed by a general practitioner); major's; resuscitation; or same day emergency care (SDEC). The SDEC model had been introduced in 2019 and had impacted positively on flow through the department. Staff were conversant with the referral criteria and they were observed to be following this during the inspection. This resulted in medically expected patients, such as those referred by a general practitioner, being directed to the SDEC service to be seen and treated by an acute medic. This meant there was no requirement for the patient to be seen by the emergency care team, thus alleviating pressure on the emergency department. The trust acknowledged the current footprint of the SDEC service impacted on its ability to see and treat more patients and so this was being considered as part of a wider review of clinical services. Following the inspection, the trust reported that, in order to decompress the minors pathway, which we had seen operating under extreme pressure during the inspection, additional same day emergency care pathways had been established. This included the opening of a gynaecology same day emergency care service. Additional focus was also being placed on the surgical same day emergency service so more patients could be managed through the pathway as compared to being held in the emergency department waiting extended periods of time for a review.

The trust had developed an emergency care dashboard which detailed the level of risk in the emergency

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department at any given time. Algorithms and capacity and demand modelling had been integrated into the dashboard to help staff across the organisation gain a better understanding of the level of patient safety risk in the ED. The dashboard captured details including the number of patients in the department, time to be seen performance, total time in the emergency department, the number of patients referred to a specialty team, and the longest time any given patient had waited to be seen once they had been referred. We noted that some patients had waited extended periods of time from being referred by the emergency team, to actually being reviewed by specialty teams. For example:

- Medicine - two patients had been referred, with the longest wait to be seen recorded as 137 minutes.
- Mental Health - four patients had been referred, with the longest wait to be seen recorded as 2,252 minutes (37 hours) (The trust reported a decision to admit had been made at 2 hours and 40 minutes and that the patient was awaiting a specialist mental health bed to become available)
- General surgery - two patients had been referred, with the longest wait to be seen recorded as 206 minutes.
- Geriatric medicine - five patients had been referred, with the longest wait to be seen recorded as 340 minutes.
- Paediatrics - two patients had been referred, with the longest wait to be seen recorded as 449 minutes (The trust reported the patient was referred at 3 hours and 40 minutes and was subsequently waiting for a specialist mental health bed).
- Urology - two patients had been referred, with the longest wait to be seen recorded as 180 minutes.

One patient who had initially been in the department for eleven hours had initially been referred to the surgical specialty; before then being referred to another specialty for assessment. On both occasions the patient had experienced delays in being assessed by the relevant specialty team, contributing to the patient remaining in the ED for an extended period of time. We also noted three further patients who had been seen by the emergency care team, and had been referred to specialty teams for review. A lack of clinical space in the minor's area meant those patients were asked to wait back in the main waiting room until the specialty team arrived to see the patients. Two patients were clearly in distress as they told inspectors their pain scores were nine in both cases;

the third patient was nauseous and actively vomiting in to a disposable sick bowl in the main waiting room; this clearly distressed not only the patient but also to others in the vicinity of the patient.

We raised the issue of delayed responses from specialty teams with the executive team as we were concerned such delays were adding to the overcrowding of the ED. The trust responded well to our concerns and reported the following by way of a regular update post inspection:

- "The Trust will mandate compliance with internal professional standards from Monday 10th February. This applies to those patients who cannot be directly streamed to Same Day Emergency Care facilities within each of the services. This change will require a senior decision maker review within 60 minutes of the request being made. All Divisional leadership teams have confirmed their support for this action. We will monitor compliance with these standards on a daily basis."
- "Staff in the ED are self-reporting that patients were seen within the 60 minutes and positively impacting on decompressing the department."
- "Medway PAS fields implemented to capture this more accurately. Compliance currently managed by the Flow Coordinators and logged on paper."

Median time from arrival to treatment (all patients)

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 over the 12 month period from December 2018 to November 2019.

Between December 2018 and September 2019, the median time to assessment was, whilst not meeting the RCEM standard, similar to the England average. However, as has been reported in the safe domain, performance against this standard was noted to be increasingly worse between October and December 2019 when compared to the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From January 2019 to December 2019 the trust's monthly percentage of patients waiting more than four hours from

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the decision to admit until being admitted was generally worse than the England average. The trust reported better performance when compared to the England average in March 2019, May 2019 and June 2019.

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

Between January 2019 and December 2019 the trust reported there were no patients waiting more than 12 hours from the decision to admit until being admitted.

Are urgent and emergency services well-led?

Requires improvement 

Leadership

The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.

At our previous inspection in 2019, we reported the senior leadership responsible for overseeing the emergency department were relatively new. The head of nursing, matron and deputy divisional director had all started between November 2018 and January 2019. The clinical director had worked at the trust for seven years and had commenced the clinical director role in 2018. At this most recent inspection, the department leaders reported feeling more "mature" in the sense they had developed as a leadership team and as their time in role had progressed, they had a better understanding of the challenges of not only the emergency department, but of the wider emergency care pathway within the trust.

Staff working in the department reported the leadership team were visible and keen to improve standards of care. Staff reported there was a more cohesive approach to addressing longstanding challenges including nurse vacancies, better access to training, and a strategy to address the wider environmental issues of the department.

At our feedback session, and in subsequent correspondence with the trust, it was clear the local leadership and the wider executive team were aware of the challenges in the emergency department. The

minor's pathway was recognised as a significant area of risk by executive members. This mirrored our concerns, and was also consistent with entries on the divisional risk register.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns.

All staff we spoke with had a strong commitment to their job and were proud of their role, team working and the positive impact they had on patient care and experience. Staff felt there was a positive working culture and reported collaborative and effective team working to provide safe care and provision. We observed healthy professional challenge among different people which suggested people respected one another. Staff advocated for patients in the majority of cases and there was an intent amongst staff to do the right thing by patients. However, environmental challenges meant that at times, the standard of care provided to patients fell below expected standards. Staff were clearly distressed and frustrated by longstanding challenges and feared that increasing demand would result in further deterioration of services should swift action not be taken.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, the system wide strategy had not delivered the anticipated outcomes.

Staff we spoke with could describe the wider vision for the trust; these were displayed throughout the emergency department (ED). At a more local level, the leadership team were committed to improving patient flow.

In 2017, the local health economy, in consultation with the wider population of Northamptonshire launched a five year urgent and emergency care strategy. The strategy recognised the increasing demand being placed on urgent and emergency care services across the whole of Northamptonshire. In considering the various work-streams and outputs of the strategy, we considered

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that, notwithstanding the fact the strategy had one year left, it had not delivered all of the outcomes first predicted. This, in part may have been linked to there being a significant and unprecedented increase in attendances to the department in 2019. The trust had projected a 4-5% increase in attendances. Instead, the trust had been required to accommodate an 8% increase. Department staff considered patients were still not being signposted to the most appropriate service, and resorted to accessing the emergency care service at Kettering General Hospital. We noted the activity of the same day emergency care service was commendable considering the limited footprint of the service. We also noted posters in the department signposting patients to access urgent care services at Corby where their condition did not meet the criteria for accessing an emergency department. The executive team reported the signage had had some impact on reducing the overall activity of the department, however, this had only been a short-term initiative introduced to decompress the acute site.

As has previously been reported, the trust was one of 14 trusts in the country selected to participate in the trial of new emergency care access standards. This meant the trust was not monitoring the traditional four hour access target (historically, all trusts were required as part of the NHS constitution, to ensure 95% of all patients attending an emergency care service were admitted, transferred or discharged within four hours). Currently, the trust was trialing a revised standard which monitored the mean (average) time patients spent in the department. The trial was further expanded to consider the mean time patients presenting with specific conditions spent within an ED, as well as developing models of care these patients should expect to receive, and within defined timescales. Although performance against the non-admitted pathway appeared to be similar to other trial sites, the trust had noted an increase in median time for patients on the admitted pathway. This had led to the leadership team engaging with specialty teams as a means of addressing the increase in median time spent. The aim was for the department to ensure patients spent only the clinically indicated amount of time in the department. Following our feedback to the trust, the trust executive team had taken swift action to ensure specialty teams followed the trust's internal professional standards protocol. This required a senior decision maker to review all patients referred to them by the ED within 60 minutes.

Although not fully tested, the trust had reported that following our inspection, there had been a commitment from all specialty teams to improve their response times to help aid in patient flow through the emergency department.

Staff spoke of new investment for an emergency care hub which was planned to be built in 2024. Plans for the hub had included the views and opinions of patients and service user however funding for the a new emergency care hub had not yet been secured. There was some anxiety among staff that the emergency care hub would not progress due to further conversations taking place which involved the redevelopment of the wider Kettering General Hospital campus in or around 2030; this new development was being designed to replace the existing hospital with a new future-proofed hospital. This therefore added a level of complexity and uncertainty in terms of the future planning for the service. Staff were anxious there would be limited investment in the emergency care service until decisions had been made as to the 2030 plan. That said, the executive team were committed to improving the children's emergency department and were also committed to the emergency care hub.

Governance and risk management

Leaders operated a governance process which considered departmental risks, incidents and quality outcomes. However, the process continued to not be fully embedded. There was poor representation at mortality and morbidity meetings which meant there was the potential for missed learning opportunities which could be used to improve patient care.

The emergency service sought reassurance through various governance meetings such as the emergency department (ED) governance meetings and mortality and morbidity meetings. The ED governance meeting was held monthly and attended by the leadership team and MDT staff. We reviewed minutes from both the September 2019, October 2019 and November 2019 ED governance meetings. The ED governance meeting was well attended by a range of health professionals. Consideration was given to incidents, serious incidents, complaints, and departmental and strategic risks.

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Commentary in the minutes that ED participation in the divisional morbidity and mortality meeting had been poor with no ED representation at the last two meetings. There was an identified action for this to be addressed by the clinical lead. It was further noted that nursing representation at morbidity and mortality meetings required improvement and so an additional action had been recorded on the urgent care action log.

It was not clear from the minutes provided whether consideration was given to longstanding issues including the quality of nursing records and patient outcomes. We had previously raised concerns with the quality of nursing records in the department. Staff reported a new nursing

record had been developed and was in the process of being ratified at the relevant committee within the trust. However, during our inspection, we identified continued concerns with the poor quality of nursing records which suggested there had not been sufficient scrutiny and oversight afforded to this by the local management team.

It was however noted a discussion had taken place in the November 2019 meeting relating to tissue pressure damage; a theme we had also identified through our analysis of incidents reported by, or against the emergency department between July 2019 and January 2020. This suggested staff were considering trends in relation to incidents being reported.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- Ensure all patients who present to the emergency department have appropriate risk assessments completed in a timely way to safeguard patients from the risk of harm.
- Ensure patients can access care and treatment in a timely way and in a suitable environment. This should include, but is not limited to the management of patients with mental health needs.

- Ensure the privacy and dignity of patients is maintained at all times.
- Ensure there are sufficient numbers of staff deployed at all times to meet the needs of patients.

Action the provider **SHOULD** take to improve

- Continue to work to address delays in patients being seen by specialty teams.
- Progress works to improve the environment in which children and young people are seen and treated.

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation

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

- Ensure all patients who present to the emergency department have appropriate risk assessments completed in a timely way to safeguard patients from the risk of harm. Regulation 12 (1)(2)(a)(b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

- Ensure patients can access care and treatment in a timely way and in a suitable environment. This should include, but is not limited to the management of patients with mental health needs. Regulation 15 (b)(c)(d)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Ensure the privacy and dignity of patients is maintained at all times. Regulation 10(a)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Ensure there are sufficient numbers of staff deployed at all times, with the right skills, to meet the needs of patients. Regulation 18(1)