Weston Area Health NHS Trust

Weston General Hospital

Quality Report

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Date of inspection visit: 12 December 2017
Date of publication: 15/02/2018

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this focused inspection to follow up on the concerns identified in a Section 29A Warning Notice served in March 2017, following an inspection of the trust. The warning notice set out the following areas of concern, where significant improvement was required:

- Systems or processes to manage patient flow through the hospital did not operate effectively to ensure care and treatment was being provided in a safe way for patients and to reduce crowding in the emergency department.
- There was inadequate hospital-wide support for the emergency department when in escalation. The escalation process was not responsive and the bed management function was not operating effectively.
- The emergency department was the single point of entry to the hospital for both emergency and expected patients, contributing to crowding. There were no direct admission pathways. This meant all GP referrals were seen in the emergency department. The emergency department did not make optimum use of the ambulatory care unit to help to improve flow and reduce crowding.
- Patients spent too long in the emergency department. There were delays in specialist review of patients, particularly at night, and admission delays from decision to admit.
- Crowding in the emergency department was a frequent occurrence. Patients queued in the corridor when there were no cubicles available. This was not an appropriate or safe place for care and treatment. Patients had no access to supplied oxygen and suction, call bells or facilities to store their belongings keep their records secure.

We conducted this follow-up inspection on 12 December 2017. The inspection was unannounced. The inspection focused solely on the issues identified in the warning notice, as described above.

The trust had achieved significant progress in addressing our concerns; however, there was still work to do. We judged that the requirements of the warning notice had not been fully met.

We found:

- Many positive changes had taken place since our last visit; new systems, staff changes and reconfiguration of premises. Further changes were in the pipeline. Some changes were very recent, not fully embedded and, in some cases not fully understood by staff. Changes appeared to have yielded benefits, seen, for example, in improved emergency department performance. However, this improvement must be viewed in the context of an emergency department which was closed at night and systems had yet to be tested when the department was fully operational.
- There was a lack of clarity and understanding amongst clinicians with regard to admission pathways. New processes had not been formalised or tested.
- The capacity and effectiveness of the ambulatory emergency care (AEC) unit was limited due to space and staffing. At the time of our inspection it operated during the day, Monday to Friday only. We were not able to obtain any data with regard to the effectiveness of the AEC and its impact in reducing crowding in the emergency department.
- On the day of our inspection patients experienced lengthy delays for admission. On arrival in the emergency department at 8am we found there were 17 patients who had attended the department the day before and were awaiting admission. We requested data and analysis in respect of these delays and historical data to show how long patients waited in the emergency department for admission, following the decision to admit. The trust did not currently capture this data.

Summary of findings

- We were unable to obtain data in respect of the time patients waited for specialist review; we were told this had improved but surgical reviews were delayed at night.
- The corridor in the emergency department continued to be used to accommodate patients when all cubicles were full. Although senior staff told us this area was used in exceptional circumstances only, data provided by the trust showed that use was increasing. In October and November 2017, 59 and 73 patients respectively spent time in the corridor.
- On the day of our inspection the corridor was in use. The physical constraints we described at our last inspection remained. Temporary curtains were in place and were used to preserve patients' privacy and dignity when being examined. However, use of curtains created a confined space in which staff examined and treated patients. Patients' records were not stored securely.
- We were concerned that unsuitable patients were placed in the corridor on arrival in the emergency department. This included a patient who was living with dementia, who was confused and combatant and a patient who, on the advice of paramedics, required cardiac monitoring. Following our inspection the trust investigated our concerns in relation to the placement of these patients in the corridor. They assured us that the nurse in charge had full oversight of the acuity of all of the patients in the department and there were no other suitable patients who could be moved to free up a cubicle space.
- The nurse in charge on the day of our inspection was not appropriately supported to manage patient flow in the emergency department.

However,

- There had been a thorough review of systems and processes to improve capacity management and patient flow, to reduce crowding in the emergency department.
- The patient flow team had been reconfigured and the bed management process had been re-designed. Staff were embracing new ways of working and were clear about their individual and team responsibilities.
- Bed meetings were structured and focused on creating capacity. Meetings were well led and well attended. There was senior presence and staff told us this was the norm.
- The trust had taken a number of steps to reduce length of inpatient stay. This included education campaigns and promotion of management tools to increase focus on patient flow.
- The trust had established an integrated discharge team and an acute frailty assessment service to support complex discharges.
- The discharge lounge had been reconfigured to become more effective and there were plans to increase its capacity and utilization.
- There had been a lot of work undertaken to develop alternative admission pathways to reduce congestion in the emergency department.
- Primary care streaming had very recently been introduced. Appropriate patients (with minor illness) were directed on arrival in the emergency department, to see an advanced nurse practitioner in the adjacent ambulatory care unit.
- The ambulatory emergency care Unit was re-modelling pathways and developing direct access pathways for GPs and the ambulance service. There were plans to increase its capacity to assess a greater proportion of expected and emergency patients.

Summary of findings

- The trust's performance against the national standard which requires that patients are admitted, transferred or discharged within four hours had improved.
- Senior clinicians told us that specialist review of patients in the emergency department was subject to fewer delays. There was a registrar physician based in the emergency department to facilitate early review of patients. There was positive feedback about the introduction of a common clerking documentation, which reduced duplication and saved time. Clerking is the recording of a patient's history, including initial investigations.
- We were pleased to note that use of the corridor for patients in ED had significantly reduced although this was now beginning to increase again. Staff told us this area was only used in exceptional circumstances. Staff were required to seek permission from senior managers to use the corridor and permission was only granted if safe levels of staffing were in place.
- We observed the corridor being used to accommodate patients on the day of our visit. The area was staffed at all times, to mitigate the environmental risks associated with this area.

The trust must:

- Continue to drive change to improve patient flow and reduce crowding in the emergency department.
- Formalise new systems and processes and ensure the engagement of staff in the change process so that new ways of working are understood.
- Embed and test effectiveness of new systems and processes through audit.
- Capture information and monitor delays in respect the time patients wait for admission following the decision to admit and any delays in specialist review of patients in the emergency department.
- Ensure that patients' records are secured to ensure confidentiality is maintained.

In addition the trust should:

- Ensure the nurse in charge in the emergency department is appropriately supported to enable efficient coordination of patient flow in the department.

Edward Baker

Chief Inspector of Hospitals

Weston General Hospital

Detailed findings

Services we looked a
Urgent and emergency services

Detailed findings

Contents

Background to Weston General Hospital

Weston General Hospital is run by Weston Area Health NHS Trust. The hospital, built in 1986, has 261 beds, with capacity to open 17 escalation beds. It provides a range of acute and rehabilitation services. The trust serves a resident population of around 212,000 people in North Somerset, with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year.

In March 2017, we conducted a comprehensive inspection of the trust's services. We identified serious concerns in relation to hospital-wide patient flow and bed management and crowding in the emergency department. We took enforcement action and the trust was required to submit an action plan setting out how it would make improvements. We have received monthly updates from the trust and this inspection was undertaken to review the progress made.

Since our last inspection in March 2017, the trust took the decision in June 2017 to close the emergency department to new admissions at night, due to safety concerns arising from a shortage of senior medical staff. This closure took effect in July 2017. This report does not specifically comment on staffing; however, it should be noted that medical staff shortage remained a problem. Recruitment was on-going at the time of our inspection and the trust anticipated that sufficient middle grade staffing levels would be achieved by May 2018, with a programme of induction to follow. The emergency department had also experienced a high turnover of nursing staff since the night-time closure and there was heavy reliance on temporary staff. We were told that there had been successful recruitment of nurses, although these new recruits were not yet in post. We will continue to monitor this and the plans to re-open the emergency department at night.

Our inspection team

Our inspection team was led by:

Elaine Scott, Inspector, supported by Alison Giles, Inspection Manager and Mary Cridge, Head of Hospital Inspections, Care Quality Commission.

The team included CQC inspectors and three specialists: a consultant in emergency medicine, an advanced nurse practitioner, and an assistant director of nursing.

Detailed findings

How we carried out this inspection

We conducted this inspection, unannounced on 12 December 2017. We spent one day in the emergency department. We visited the ambulatory emergency care unit, the discharge lounge and we spent time with the site management team.

During our visit we spoke with approximately 20 staff, including doctors, nurses, and managers. We spoke with six patients and looked at six patients' records.

Urgent and emergency services

Safe	
Responsive	
Overall	

Information about the service

Urgent and emergency care services are provided in the hospital's emergency department seven days a week, 365 days a year. The department is open from 8am until 10pm. Night time closure has been in place since July 2017 due to safety concerns relating to a shortage of senior medical staff. Between August 2016 and July 2017, the emergency department saw 52,506 patients, of which 8,925 were children. Twenty-eight percent of attendances arrived by ambulance and 23% were admitted to hospital. There is no paediatric cover at night or at weekends and children are taken by ambulance to Bristol or Taunton.

There are two treatment areas. Patients with serious injuries or illnesses, who mostly arrive by ambulance, are seen and treated in the major treatment area, which includes a resuscitation area with four trolleys. The major treatment area is accessed by a dedicated ambulance entrance. Self-presenting patients with minor injuries or illness are assessed and treated in the minor treatment area or streamed to the adjacent primary care assessment area.

There is an adjacent ambulatory emergency care (AEC) unit which provides same day urgent assessment and treatment for ambulant patients, who are not predicted to require admission to hospital. This includes patients directly referred by GPs or the ambulance service, or patients who have attended the emergency department and who meet the suitability criteria. At the time of our inspection there was building work in progress and the AEC was sharing accommodation with the emergency department triage function, surgical assessment unit staff and a primary care nurse. The capacity of the department was limited by space and staffing constraints and was operational during the day, Monday to Friday only, although there were plans to extend this. Primary care streaming had been introduced six weeks prior to our inspection, allowing low acuity patients (patients with minor illness) to be diverted away from the emergency department. The service was nurse-led and there were plans to introduce GP assessment in the new year.

Our inspection took place on an exceptionally busy day for the trust. Approximately 40% of the hospital's inpatient beds were closed due to an outbreak of Norovirus. When the emergency department opened at 8am there were 17 patients who had been accommodated in the department overnight, waiting for admission. Patient flow was slow throughout the day, resulting at times in gridlock and congestion in the emergency department, when patients had to be accommodated in the corridor.

Urgent and emergency services

Summary of findings

- This was a follow up inspection of urgent and emergency care to assess whether the trust had made sufficient progress in response to the Section 29A warning notice issued in March 2017. We judged that significant progress had been made; however, change was ongoing and new systems were not embedded or tested. Progress was constrained by staff shortages, which meant that the emergency department continued to be closed at night. We judged the requirements of the warning notice had not been fully met.
- We have not reviewed the rating for this service because of the limited focus of this inspection. The rating therefore remains inadequate overall.

We found:

- Many positive changes had taken place since our last visit; new systems, staff changes and reconfiguration of premises. Further changes were in the pipeline. Some changes were very recent, not fully embedded and, in some cases, not fully understood by staff. Changes appeared to have yielded benefits, seen, for example, in improved emergency department performance. However, this improvement must be viewed in the context of an emergency department which was closed at night and systems had yet to be tested when the department was fully operational.
- There was a lack of clarity and understanding amongst clinicians with regard to admission pathways. New processes had not been embedded or tested.
- The capacity and effectiveness of the ambulatory emergency care unit was limited due to space and staffing. At the time of our inspection it operated during the day, Monday to Friday only. We were not able to obtain any data with regard to the effectiveness of the AEC and its impact in reducing crowding in the emergency department.
- On the day of our inspection patients experienced lengthy delays for admission. On arrival in the emergency department at 8am we found there were 17 patients who had attended the department the day before and were awaiting admission. One patient spent 24 hours in the emergency department and waited 20 hours for a decision to admit them to hospital. The trust was unable to provide data to show how long patients waited for admission to a ward following the decision to admit or how long patients waited for specialist review.
- Although staff told us the corridor in the emergency department was only used in exceptional circumstances, data provided by the trust showed that use over the last few months was increasing.
- On the day of our inspection the corridor was used to accommodate patients when all cubicles were full. The same physical constraints we observed at our last inspection were evident and, while staff took steps to preserve patients' dignity, this was challenging in this environment. Patients' notes were not securely stored and ambulance staff experienced difficulty manoeuvring trollies in this confined space.
- We were concerned that unsuitable patients were placed in the corridor on arrival in the emergency department. This included a patient who was living with dementia, who was confused and combatant. Following our inspection the trust investigated our concerns in relation to the placement of these patients in the corridor. They assured us that the nurse in charge had full oversight of the acuity of all of the patients in the department and there were no other suitable patients who could be moved to free up a cubicle space.
- Nurse staffing on the day of our inspection was below establishment. There was no streaming nurse, administrative support or senior sister, and a nurse from the ambulatory emergency care unit was redeployed to staff the corridor. While staffing levels were safe, this impacted on efficient patient flow.

However,

- There had been a thorough review of systems and processes to improve capacity management and patient flow in the hospital, to reduce crowding in the emergency department.

Urgent and emergency services

- The trust had taken a number of positive steps to reduce length of inpatient stay. This included staff education campaigns and promotion of management tools to increase focus on patient flow.
- The trust had established an integrated discharge team and an acute frailty assessment service to support complex discharges.
- The discharge lounge had been reconfigured to become more effective and there were plans to increase its capacity and utilisation.
- There had been a lot of work undertaken to develop alternative admission pathways to reduce congestion in ED.
- Primary care streaming had very recently been introduced, allowing low acuity patients to be diverted form the emergency department. There were plans to extend this service.
- The ambulatory emergency care unit was re-modelling pathways and developing direct access pathways for GPs and the ambulance service. There were plans to increase its capacity to assess a greater proportion of expected and emergency patients.
- Wards had been reconfigured and a new medical assessment unit had very recently opened, located close to the emergency department. This would allow direct admission of GP-referred patients 24 hours a day.
- The trust's performance against the national standard which requires that patients are admitted, transferred or discharged within four hours had improved.
- The trust was meeting national standards in respect of the time patients waited for initial assessment and the time they waited for treatment. The proportion of patients who left the emergency department before being seen was below (better than) the national standard.
- There had been no 12 hour trolley waits in the last 12 months.
- Staff in the emergency department told us the review of patients in the emergency department was subject to fewer delays, although there was no data to support this. There was a registrar physician based in the emergency department to facilitate early review of patients. A common clerking pro-forma had been produced to avoid duplication and save time. Clerking is the recording of a patient's history, including initial investigation results.
- Senior staff told us that use of the corridor in the emergency department for patient care and treatment had significantly reduced and was only used in exceptional circumstances. Staff were required to seek permission from senior managers to use the corridor and permission was only granted if safe levels of staffing were in place.
- We observed the corridor being used to accommodate patients on the day of our visit. The area was staffed at all times, to mitigate the environmental risks associated with this area.
- Patients, who were accommodated overnight in the emergency department because they were waiting for beds, were well cared for. We saw excellent nurse documentation which provided evidence that safety and comfort checks were undertaken regularly. Patients were transferred to a bed and were offered hot food and drinks. Patients, while frustrated with delays, told us they had been well cared for.

Urgent and emergency services

Are urgent and emergency services safe?

At our last inspection we were concerned about the safety of patients, who were frequently accommodated in the emergency department corridor, when all clinical areas were full. This was not a suitable or safe environment for patients to receive care and treatment. During our follow up inspection we found:

- Use of the corridor for patient care and treatment had reduced, although was beginning to increase again. Staff were required to seek permission to accommodate patients in the corridor and the area was only used if it could be adequately staffed. There were defined staffing levels and patients in the corridor were not left unattended.
- There was a protocol for the management of patients in the corridor. Senior staff were required to risk assess patients in the major treatment area to ensure that the most suitable patients were identified for care in the corridor.

However,

- Although senior staff told us the use of the corridor was not the norm, its use had increased over the last few months. On the day of our inspection patients were accommodated in the corridor. They included patients who, in our judgement, were not suitable to be cared for in this area, including two patients who were confused. We were assured that there were no other suitable patients in the department at the time, who could be moved to free up cubicles for these patients. The physical constraints of this area, which we identified previously, still existed; congestion, lack of call bells, piped oxygen and monitoring equipment, and lack of a secure place to store patients' records.

Environment and equipment

- At our last inspection we reported that the emergency department was frequently crowded, with patients being held in a corridor until space became available in the major or minor treatment areas. This was a frequent and regular occurrence. We were concerned that patients in this area did not have access to call bells, piped oxygen or cardiac monitoring equipment, and there was nowhere to secure patients' records.
- During our follow up inspection we were pleased to learn that use of the corridor had reduced, although its use had increased over the last few months. On the day of our visit, when patient flow was particularly poor due to bed shortages in the hospital, some patients were accommodated in the corridor. While the same physical constraints still existed, the risks were mitigated to some extent by ensuring that patients were not left unattended.

Records

- At our last inspection we reported that patients' records were not securely stored when patients queued in the corridor. During our follow up inspection we found this was still the case. We saw patients' records lying on top of a table, accessible to anybody in that area.

Assessing and responding to patient risk

- There was a standard operating procedure for managing patients in the emergency department corridor. This required that the nurse in charge and consultant should review all patients in the major treatment area and patients who had been assessed and were stable would be prioritised for the corridor above any unassessed patients. This was known as 'reverse queuing'. During our inspection we saw that unassessed patients were placed on the corridor on arrival in the department. This included a patient, who, on the advice of paramedics, required cardiac monitoring and two elderly confused patients, one of whom was identified as possibly having sepsis. Sepsis is a potentially life-threatening complication of an infection.
- The trust investigated our concerns regarding the placement of these patients in the corridor and assured us that the decisions were made with full oversight of the acuity of all patients in the department. The patients received one to one care while they were in the corridor.
- There was not a consistent understanding of the escalation process amongst senior clinicians in the emergency department. We were told by a senior clinician that the emergency department did not determine its own escalation status and some senior staff were not aware of the hospital's operational pressures escalation level (OPEL) on the day of our visit. There were was an escalation card for the emergency department which described the levels of escalation, the triggers for each level and the actions to be taken at

each level. This could not be found when we requested it but was later provided. This suggested to us that the formal escalation process was not being consistently adhered to; the process was more informal, based on the discretion and judgement of the senior clinicians. There were two hourly reviews of the department (called 'board rounds') with the nurse in charge and the consultant in charge to ensure oversight of the department as a whole. They had signed a sheet to confirm that this round had taken place but their decisions in relation to escalation were not documented.

Nursing staffing

- During our inspection, we saw that nurse staffing had been adjusted to ensure there were appropriate staff to patient ratios in the corridor. Senior staff anticipated corridor use early in the day and brought in agency staff to ensure that there was adequate cover in the department. There were two nurses employed on the day of our inspection to care for patients in the corridor. Both of these nurses were agency nurses, which was not in accordance with the protocol for the management of patients in the corridor. This stated that the nurse in charge would identify a nurse from the current nursing establishment to monitor the corridor.
- We observed that the nurse in charge was under immense pressure during our inspection. They were responsible for assessing patients on their arrival in the department, as well as managing patient flow in and out of the department. We were told that they were normally supported by a staff member, known, as a 'tracker', who would undertake administrative duties, such arranging patient transfers, chasing beds and answering the telephone. This role was not filled (there were a number of vacancies) and duties fell to the nurse in charge. There was normally a band seven nurse who had overall responsibility for the management of patient flow in the department but they were also absent on the day of our inspection. The associate director of nursing was present in the department some of the time to provide support.

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

At our previous inspection we were concerned that patient flow in the hospital was not effectively managed so as to reduce crowding in the emergency department. The emergency department was not well supported by the rest of the hospital when they were in escalation. Specialist review of patients in the emergency department was frequently delayed, particularly at night. The emergency department was the single point of entry to the hospital for both emergency and expected patients, contributing to crowding. There were no direct admission pathways. This meant all GP-referred patients were seen in the emergency department. The emergency department did not make optimum use of the ambulatory emergency care (AEC) unit to help to improve flow and reduce crowding. Patients spent too long in the emergency department, particularly when they were waiting for a bed. Patients were frequently cared for in the corridor, because of a lack of space in clinical areas. This impacted on their comfort, privacy and dignity.

During our follow up inspection we found:

- There was poor patient flow on the day of our inspection, due to a shortage of beds in the hospital. Forty percent of medical beds were closed due to an outbreak of Norovirus. When we arrived in the emergency department at 8am there were 17 patients, who had been accommodated overnight, while waiting for beds. While we understand this was an exceptional day, we could not obtain historical data to show how long patients normally waited from the decision to admit to the time they were admitted as this was not captured by the hospital's electronic records system.
- There was not a consistent understanding of the escalation process amongst senior clinicians in the emergency department, and it was not evident that they were consistently adhering to the escalation policy.
- There was a lack of clarity amongst clinicians with regard to admission pathways for patients referred by their GPs. Many changes were still in train and had not been embedded or tested

Urgent and emergency services

- The primary care function, established to support the emergency department was not always operating efficiently. The service was not able to proactively 'pull' patients from the emergency department queue or to refer patients to specialty inpatient teams within the hospital.
- The capacity of the ambulatory emergency care unit was limited due to space and staffing and was currently operating during the day, Monday to Friday only. We were not able to obtain data to show the performance and effectiveness of this department.
- Staff told us that delayed specialist surgical review in the emergency department continued to be a problem, particularly at night. The trust did not capture data to monitor this.
- Patients were accommodated in the emergency department corridor on the day of our inspection. This was not a dignified or comfortable experience. Patients included a patient living with dementia, who was confused and combatant.

However,

- Systems and processes to manage patient flow through the hospital had been reviewed and strengthened. The patient flow team had been reconfigured and bed management meetings re-structured to ensure focus on creating capacity within the system. Senior staff were driving change and improvement.
- There was greater focus on reducing delays in the discharge process, and reducing patients' length of stay in hospital. An integrated discharge team and a frailty team proactively supported ward staff to facilitate the discharge of complex patients. There had been education and promotion of management tools for inpatient teams to ensure a more efficient discharge process and better patient flow.
- There was evidence of regular dialogue between the patient flow team and the emergency department. There was a clear escalation process and action cards for individuals, teams and departments in the event that demand outstripped capacity.
- The trust had done a lot of work to develop alternative admission pathways. A nurse-led primary care service had very recently been established to support the emergency department, allowing low acuity patients to be diverted from the emergency department. There were plans to extend this service to provide GP assessment.
- The trust was re-modelling pathways into the ambulatory emergency care unit, with a view to increasing its capacity to assess patients, who would otherwise have attended the emergency department.
- Wards had been reconfigured and a new medical assessment unit, located close to the emergency department, had very recently opened. This enabled the direct admission of GP-referred patients 24 hours a day.
- The trust had improved its performance against the standard which requires that 95% of patients are discharged, admitted or transferred within four hours.
- Use of the corridor in the emergency department to accommodate patients at times of crowding had reduced, although it was increasing again, and use was strictly controlled to ensure that it did not become the norm.
- Nurse documentation provided evidence that patients who were accommodated overnight in the emergency department received regular checks and were well supported by staff to ensure their comfort and wellbeing. This included the provision of beds and food and drink.

Meeting people's individual needs

- We previously reported concerns that patients were frequently accommodated in the emergency department corridor when there were no suitable clinical areas available. This was not a suitable area for patients to receive care and treatment. We were pleased to note that this practice was less frequent, although, data provided by the trust showed it had increased over the last few months. In October and November 2017, 59 and 73 patients respectively spent time in the corridor.
- On the day of our inspection the corridor was being used to accommodate patients. There was curtain tracking in place along the corridor so that temporary curtains could be hung in the event that the corridor was used. We saw staff taking steps to preserve patients' dignity but this was challenging in this environment.

- We saw two patients placed in the corridor on arrival by ambulance, despite them being confused. The trust's Standard Operating Procedure for Managing Patients in the Corridor stated: 'Cognition and behaviour must be considered as these may be harder to manage in a corridor setting.' In one of these two cases, the consultant questioned the decision of the nurse in charge to place a patient in the corridor. This was a patient who was living with dementia and who was confused and combatant. The nurse over-ruled the consultant and the patient was accommodated in the corridor for two hours, before being moved to a cubicle. We asked the trust to investigate our concerns about the placement of this patient in the corridor. They told us the nurse in charge had full oversight of the acuity of all patients in the emergency department and there were no other suitable patients who could be moved there to free up a cubicle space. The patient received one to one care while they were in the corridor.

Access and flow

- At our previous inspection we were concerned that patient flow in the hospital was not effectively managed so as to reduce crowding in the emergency department. The emergency department was not well supported by the rest of the hospital when it became crowded.
- At our follow-up inspection two members of our inspection team spent the day reviewing the management of patient flow. We saw that the trust had reviewed systems and processes to manage patient flow and the patient flow team had been reconfigured. There was senior leadership of this function and senior presence at regular bed management meetings.
- We attended the first two bed management meetings of the day. Meetings were regular, throughout the day and were well structured and well led. Staff had embraced new roles and new ways of working. There was clear accountability for undertaking tasks, such as expediting discharges, following each meeting. It was clear that patient flow was everyone's priority and any actions agreed at meetings were discussed at the next meeting to review progress. All senior nursing staff were advised to clear their diaries to support plans and staff were encouraged to "shout early and loud" and to look ahead and target additional numbers for discharge. At the 12:30pm meeting, staff were tasked with presenting two patients for discharge the next day at the 3pm meeting.
- There was evidence of regular dialogue between the patient flow team and the emergency department. Senior staff in the emergency department told us they felt well supported by the patient flow site management team, although more junior staff did not agree with this.
- There was a trust-wide escalation policy which set out responses to defined levels of pressure, in accordance with NHS England's Operational Pressures Escalations Levels (OPEL) Framework. There were action cards for individuals, teams and departments, in the event that demand outstripped capacity.
- There was an escalation crowding tool which enabled the emergency department to define its own current escalation status or OPEL level using a set of triggers. This included delayed ambulance handover, delayed assessment, staffing shortage or crowding. There were actions set out for each OPEL level, including escalation to various levels of management in the trust. The consultant in charge on the day of our inspection told us that the emergency department did not calculate its own OPEL status and the action card for the emergency department could not immediately be found. We were not assured therefore that policy was embedded in use or used consistently.
- There was greater focus on reducing delays in the discharge process, and reducing patients' length of stay in hospital. A 'red to green' initiative had been introduced on all inpatient wards. This is a visual management system used to identify wasted time in a patient's journey. This was used in conjunction with best practice guidance issued by NHS Improvement, known and the SAFER patient flow bundle. This incorporates five elements of best practice: S= senior review of all patients by midday, A= all patients will have an estimated discharge date, F= flow of inpatients to commence at the earliest opportunity. Wards should routinely receive patients from assessment units by 10am, E= early discharge - 33% of discharges should take place before midday, and R=Review: A systematic multidisciplinary review of all patients with extended lengths of stay. The trust monitored compliance with best practice, which was mixed but showing an improving trend.
- There was collaborative working with colleagues in primary care, social care and with clinical commissioning groups (CCGs). There was daily contact

with one CCG and weekly contact with another, via teleconferencing. We observed system-wide teleconferences. There was discussion about the bed status in the hospital, including the beds closed due to Norovirus. There was a detailed discussion about individual patients whose discharge was delayed. Packages of care, care home placement, equipment needs, family choice and funding were discussed and administrative staff updated the live database during the calls. Issues were escalated, internally, to the general manager and the director of operations and externally, to social services' managers.

- The patient flow team recognised that too many patients were 'stranded' in acute beds and no longer required acute hospital care. We were told there were twice-weekly stranded patient reviews with all commissioning, community health, and social care system partners. This was for all patients who were medically fit for discharge after seven days, with a view to accelerating discharge.
- The trust introduced an integrated discharge service to all inpatient wards in May 2017. This team supported early assessment of complex patients, and support to ward staff in developing and implementing discharge plans.
- An Acute Frailty Assessment Service was established in June 2017 to support early assessment, treatment and early supported discharge of frail elderly patients. There was positive feedback from the patient flow team and staff in the emergency department about this service. There was good engagement with the emergency department. We saw that they attended the mid-morning ward round to see how they could help. There were plans to increase consultant input to this team.
- We visited the discharge lounge, which had been reconfigured to make it more effective. Operating hours had been extended, and the service operated from 8am to 8pm, Monday to Friday. A breakfast service was provided to facilitate early morning transfers and exclusion criteria had been reduced. The trust's Discharge Lounge Standard Operating Procedure (November 2017) set out a referral and transfer procedure, whereby the discharge lounge team actively 'pulled' patients who had been identified by wards as suitable for transfer there. There were plans to further extend the capacity of this service, increasing from one bed to two and from six chairs to 12. There were also plans to extend the service from its current Monday to Friday provision to cover seven days a week, when sufficient staffing was in place. Staff told us the discharge lounge accommodated approximately 15 patients per day, which represented 20-25% utilisation. They were aiming to increase utilisation to 85 to 90%. On the day of our visit, it was reported at the 12:30pm bed meeting that nine patients had been transferred to the discharge lounge. Work had begun to produce an electronic referral form to speed up this process and to produce performance information to demonstrate the effectiveness of this service.
- We reported at our last inspection that the emergency department was the single point of entry to the hospital for both emergency and expected patients, contributing to crowding. There were no direct admission pathways. This meant all medical, surgical or oncology patients were seen in the emergency department. We also reported that the emergency department did not make optimum use of the ambulatory emergency care (AEC) unit to help to improve flow and reduce crowding.
- Since our last inspection the trust had done a lot of work to develop alternative admission pathways and to reduce congestion in the emergency department. A nurse-led primary care service had recently been established to support the emergency department. The service operated from 8:30am to 6pm, seven days a week and there were plans to extend these hours and to provide GP assessment in the New Year. There was a streaming nurse employed in the emergency department reception area, who was able to direct appropriate patients to be seen by an advanced nurse practitioner. As this was a new service, the trust was not able to provide any data to show how many patients had been seen by the primary care nurse or how effective this service was; however we viewed this as a positive development. The trust's Primary Care and Clinical Navigation Standard Operating Procedure (October 2017) set out key performance indicators on which the service would be measured in the future.
- On the day of our inspection, the streaming nurse employed when we arrived in the emergency department was soon redeployed to perform triage, due to a staff shortage. Staff told us this occurred quite

frequently. This meant the process became less efficient as patients waited to be triaged. The primary care nurse was able to see the emergency department board but was not permitted to proactively 'pull' patients from the queue. They were also not able to refer to specialties and patients requiring specialty review were referred back to the emergency department, which appeared inefficient. It was explained to us that this was because the requirement for specialty review would indicate that the patient was not low acuity and therefore the streaming process had failed.

- There was a lack of clarity with regard to the pathway for GP expected patients; clinicians had differing understanding of the process. We felt this was understandable, given that the service was undergoing significant change.
- The patient flow team handled the bleep for GP referrals and were able to advise on the most appropriate admission route. There were plans for this service to be undertaken by the ambulatory emergency care unit (AEC), when they were fully operational.
- The AEC was going through a period of change. Admission pathways were being re-modelled, with a view to enabling this department to assess all expected patients, thereby avoiding an emergency department attendance. There was a draft Standard Operating Procedure which set out the types of patients who could be assessed here, and set of exclusion criteria. There were surgical hot clinics (where patients could be seen the same or the next day, in order to prevent admission) and GPs were able to refer directly to AEC, as were the ambulance service and outpatients clinics, if suitability criteria were met.
- Emergency department staff were also able to refer suitable ambulant patients for assessment the same day or for post-discharge review the following day. There was some concern expressed by staff that patients referred by the emergency department were not time critical, in other words, the time they spent in the department was not measured against the four hour standard. Staff were concerned about some patients "getting lost". They told us that sometimes patients waited to be seen in the AEC, only to be referred back to the emergency department when the AEC closed. The trust was not able to provide performance data to show how effectively the department was operating and its impact in reducing crowding in the emergency department.
- Emergency department clinicians told us that their AEC colleagues were not proactive in 'pulling' patients to support the emergency department. Although they had access to the emergency department board, they did not attend emergency department board meetings.
- At the time of our inspection, building work was taking place and AEC capacity was limited due to space, which was shared by multiple services (surgical assessment unit, emergency department triage and primary care). Operating hours had reduced significantly over the last few months and the unit was currently operating from Monday to Friday only. Weekend opening was not possible due to staffing constraints. Staff did not feel engaged in the change process.
- We were told about the recent reconfiguration of wards and the opening of a new 14-bedded medical assessment unit (MAU), located adjacent to the emergency department. There were 10 assessment beds and four observation beds. This became operational three days prior to our inspection so we were not able to assess its effectiveness. The trust's Operational Policy - Medical Assessment Unit (December 2017) described the function of this unit to provide rapid assessment, investigation, diagnosis and stabilisation of condition for medical emergency patients over the age of 16. The MAU would accept expected patients referred by their GP, once triaged in the ambulatory emergency care unit. The aim was to ensure there were two bed spaces on the unit in order that the rapid assessment function could be maintained. Patients were expected to stay on the unit for six to 12 hours only to ensure it continued to function effectively. Patients were accepted 24 hours a day, even when the emergency department was closed. There was a Standard Operating Procedure for the Direct Admission of GP-referred medical patients to MAU following ED overnight closure (July 2017), which set out the referral and admissions process, suitability and exclusion criteria.
- There was a direct admission pathway for patients with a fractured neck of femur, and for stroke patients, which, staff told us, worked well.

Urgent and emergency services

- We previously reported that patients spent too long in the emergency department, particularly when they were waiting for a bed. There were delays in specialist review of patients in the emergency department, particularly at night.
- Performance data showed that the trust's performance against the national standard, which requires that 95% of patients are admitted, discharged or transferred within four hours, had improved since our last inspection. Performance in the year to date (April to October 2017) was 88.5%. In the same period, 95% of patients or less spent 6.3 hours in the emergency department. The trust consistently met the standard which requires that the time patients wait for treatment is less than one hour. In October 2017, performance was 35 minutes. All of these performance metrics were showing an improving trend. However this performance should be viewed in the context of an emergency department which had been closed at night to new admissions since July 2017.
- We requested data in respect of the time that patients waited for admission from the decision to admit. The trust was not able to provide this data because it was not captured by the electronic records system. The trust was working on a solution to this.
- On the day of our inspection patients experienced lengthy delays for admission. Data and analysis provided by the trust showed that there were 50 breaches of the four hour standard; performance was 58.6%. When we arrived in the emergency department at 8am there were 17 patients who had attended the emergency department the day before and were awaiting admission. Performance for the day prior to our visit was 78.3% and there were 24 breaches. We drew to the trust's attention the experience of a patient who spent 24 hours in the emergency department and waited 20 hours before a decision to admit was made.
- We also requested data in respect of delayed specialist review but the trust was not able to provide this. Senior clinicians in the emergency department told us this this had improved. There was a registrar physician based in the emergency department to facilitate early review of patients. However, there was no surgical cover after 8pm, and we were told that delayed surgical review continued to be a problem. There was positive feedback about the introduction of a common clerking pro-forma, which reduced duplication and saved time. Clerking is the recording of a patient's history, including initial investigation results. New documentation required that this was only recorded once.
- The trust had recently introduced a pre-emptive transfer policy, which facilitated the early transfer of a patient requiring admission to a ward where a discharge was anticipated. This is known as 'boarding' and it is a practice supported by the Royal College of Emergency Medicine because it shares the risk associated with crowding. The policy had only been implemented once at the time of our inspection.