

Portsmouth Hospitals NHS Trust

Queen Alexandra Hospital

Quality Report

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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.

Ratings

Urgent and emergency services

Not sufficient evidence to rate



Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this unannounced focussed inspection in response to concerns about the safety and quality of patient care during the winter months, when the trust has been under extreme pressure. Increased demand for services, a high incidence of flu, and poor outflow from the hospital had resulted in high bed occupancy and insufficient inpatient capacity in the hospital. This has led to crowding and extended waits for patients in the emergency department and has resulted in inpatients being cared for in outlying 'escalation' areas, not designed for inpatient care.

We did not rate this service due to the limited focus of our inspection. We looked at specific key lines of enquiry under three of our five key questions; Is the service safe, responsive and well led?

We found:

- The trust's escalation status during the months of December 2017, January and February 2018 indicated that they experienced significant and extreme operational pressures, due to insufficient capacity to meet demand for services, for much of this time. This put patients at risk.
- The emergency department was frequently crowded; patients were cared for in corridors and in ambulances outside the emergency department. Patients experienced delays in their assessment, treatment and admission to a hospital bed. When there was insufficient inpatient capacity, patients were cared for in unsuitable outlying and escalation areas, some of which were not designed for inpatient care.
- There were frequent delays in ambulance staff handing over care of patients to emergency department staff. This included a significant number of delays of over one hour, known as black breaches, and ambulance staff being unable to offload their patients. This not only delayed patients' assessments in the emergency department, but also delayed ambulance staff who were not available to respond to further calls.
- Patients were not always promptly assessed on arrival in the emergency department to identify or eliminate any serious or life threatening illness or injury. Processes to stream and triage patients on their arrival in the emergency department were not operating efficiently or effectively.
- Staff in the emergency department did not consistently complete safety checklists so we could not be assured that patients were regularly monitored to ensure their on going safety and comfort.
- Patients experienced lengthy delays in the emergency department. The trust was consistently failing to meet the national standard which requires that 95% of patients are admitted transferred or discharged within four hours. A significant number of patients waited up to 12 hours in the emergency department from the time a decision was made to admit them to the time they were admitted. The trust's performance was significantly worse than the England average.
- The emergency department was not adequately staffed at night. The department had assessed that two middle grade doctors were required at night but currently night time cover was provided by only one. Junior medical staff felt unsupported and vulnerable at night and consultant staff were frequently working additional hours to support their junior colleagues. It was felt that this was not sustainable.
- Patients were frequently accommodated in corridor areas of the emergency department, when all assessment and treatment areas were full. These areas were not suitably equipped and did not facilitate easy monitoring of patients held there. Queuing caused congestion, which hampered the movement of patients, staff and equipment in these areas. Despite the efforts of staff, patients' comfort, privacy and dignity needs could not be met.

Summary of findings

- Inpatients were frequently cared for in unsuitable outlying areas of the hospital. This meant they were admitted to a ward in a speciality other than that which they were assigned to. We could not be assured that staff caring for these patients had the necessary skills and experience to meet these patients' needs.
- Patients were frequently cared for in departments (designated as escalation areas) which were not designed, equipped or staffed for inpatient care.
- There was a lack of effective governance to provide assurance that escalation areas were being used in a safe and appropriate way.
- The regular and frequent use of day case departments as escalation areas impacted on their 'business as usual' activity, their ability to function efficiently, and resulted in some elective day case procedures being cancelled.
- Patients experienced frequent bed moves, often at night, which impacted on their comfort and wellbeing.
- The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The trust's winter resilience plan had not been effective and had not yielded the required capacity and flow to manage the significant pressures the trust faced during the winter months. We questioned the effectiveness of the plan, the apparent lack of robust challenge and review in the face of failing systems, and whether planning for winter had begun soon enough.
- Although the risks associated with poor flow and capacity were understood at a senior level in the trust, the corporate risk register did not accurately or fully reflect the serious risks to patient safety and quality.
- Appropriate and accurate information was not always available or used effectively to monitor, manage and report on quality and safety. The trust was unable to provide us with key data, which could be used to provide assurance of quality and safety and inform and drive improvements.
- There was a lack of assurance in regard to the effectiveness of safety systems in the emergency department.

However:

- There was commitment to deliver improvement at a senior level in the trust. There were many streams of work on going to change internal processes to improve patient flow and operational performance. Alongside this there was a system-wide capacity and demand review led by commissioners to establish the level of capacity required to improve flow across the health and social care system.
- There was evidence that staff in the emergency department consistently used a screening tool to identify suspected sepsis and followed guidance to ensure prompt treatment.
- Patients attending the emergency department with acute mental illness were assessed using a recognised mental health risk assessment. The trust monitored compliance with this and had performed at above 90% since November 2017.
- There was a dedicated discharge ambulance, which had been funded from December 2017 through to March 2018, which staff told us was very helpful in facilitating patient discharges and improving patient flow.

Importantly, the trust must:

- Review the effectiveness of the winter resilience plan and its failure to yield sufficient capacity to improve patient flow and reduce crowding in the emergency department.
- Review the corporate risk register to ensure the risks associated with capacity are fully captured and actions to mitigate risk are regularly reviewed by the board.
- Set clear targets and milestones, review progress and challenge failure.

Summary of findings

- Improve monitoring systems; use timely and appropriate data to provide assurance of quality and safety and drive improvement.
- Continue to drive initiatives to reduce length of inpatient stay and improve patient flow.
- Fully embed new systems in the emergency department used to assess and monitor risks to patients, and audit their effectiveness.
- Take steps to ensure the emergency department is adequately staffed at night.
- Review the governance systems in relation to the use of escalation areas, to provide assurance that they are appropriately used, and appropriately staffed and equipped.

We have written to the trust outlining our concerns and asked that they respond to these urgently. We will follow up on these concerns at our scheduled comprehensive inspection of trust services in April 2018.

Professor Edward Baker
Chief Inspector of Hospitals

Queen Alexandra Hospital

Detailed findings

Services we looked at

Urgent and emergency services;

Detailed findings

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Background to Queen Alexandra Hospital

Queen Alexandra Hospital is a 1200 bedded District General Hospital providing a comprehensive range of acute and specialist services to a local population of approximately 208,900 people.

Our inspection team

Our inspection team was led by:
Fiona Wray, Inspection Manager

The team included three CQC inspectors and three specialist advisors: A consultant in emergency medicine, a senior emergency department nurse, and a mental health specialist.

How we carried out this inspection

We conducted this inspection, unannounced on 28 February and 1 March 2018. We spent time in the emergency department, visited escalation areas and attended bed management meetings.

We spoke with approximately 25 staff, including doctors, nurses and managers. We spoke with 10 patients and looked at 15 patient records.

Urgent and emergency services

| | | |
|------------|---------------------------------|---|
| Safe | Not sufficient evidence to rate | ● |
| Responsive | Not sufficient evidence to rate | ● |
| Well-led | Not sufficient evidence to rate | ● |
| Overall | Not sufficient evidence to rate | ● |

Information about the service

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. The emergency department (ED) is open 24 hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries that need prompt treatment, such as lacerations and suspected broken bones. There were 148,515 ED attendances from October 2016 to September 2017, of which 31,771 were children.

The emergency department is a recognised trauma unit. Major trauma patients are transported directly to the nearest major trauma unit. The department has a four-bay resuscitation area, with one bay designated for children. There are two major treatment areas; majors 1 has 18 bays and three cubicles, majors 2 has six bays and four chairs (with a trolley for clinical examination). There is a separate 'pit stop' assessment area with six trolleys and four chairs. In the event that the pit stop area is full, up to six patients are accommodated in the corridor while they wait for assessment. Two further corridor areas are used when the department reaches capacity.

There is a nine-bed emergency decision unit (EDU). This area comprises of two four-bed bays and a single-bed side room. The area is used for patients who are unlikely to require admission but who require short term observation or are waiting for test results. The unit is regularly used to accommodate patients with acute mental health problems who are waiting for assessment by a mental health practitioner or waiting for a mental health bed. There is a side room designated for mental health practitioners to undertake mental health assessments. The unit also accommodates frail elderly patients.

The minor treatment area has six treatment cubicles and two consultation rooms used by general practitioners to provide an urgent care service. This service operates from 8am to 11pm, seven days a week and sees patients who present with a condition which requires immediate treatment, but which can be carried out by a GP.

The emergency department has a separate children's treatment area with its own secure waiting room. This consists of an observed play area, an HDU, an isolation room, five majors cubicles and four minors cubicles. This area is open from 8am until midnight, seven days a week. Outside of these hours, children are seen in the main (adult) area of the emergency department or they are taken directly to the children's assessment unit, located elsewhere in the hospital.

We carried out an unannounced inspection of urgent and emergency care on 28 February and 1 March 2018. This was a focussed inspection in response to our concerns about the safety and quality of patient care during the winter months when the trust has been under extreme pressure. Increased demand for services, a high incidence of flu, and poor outflow from the hospital has resulted in high bed occupancy and insufficient inpatient capacity in the hospital. This has led to crowding and extended waits for patients in the emergency department and has resulted in inpatients being cared for in outlying 'escalation' areas, not designed for inpatient care.

Our on going monitoring of the trust has identified that there have been significant ambulance delays, delayed initial assessment, crowding and long waits in the emergency department. There has been extensive use of escalation areas for inpatient care during the winter months. Three whistle blowers have contacted us with concerns about patient safety and undue pressures placed on staff. A serious incident occurred in December 2017, when a patient experienced a significant delay in

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diagnosis and treatment, with a four hour wait on an ambulance outside the emergency department and a seven hour wait to see a doctor. The trust declared an internal critical incident on 28 December 2017 and this continued into the first week of January 2018.

High bed occupancy, outlying and crowding in emergency departments are associated with an increase in mortality. They also impact on patients' experience; long waits, lack of appropriate facilities, comfort, privacy and dignity.

We looked at three of our key questions; is the service safe, is it responsive to people's needs and is it well led?

During our inspection the trust was experiencing significant pressure. We were told there were approximately 300 inpatients, who were medically fit for discharge but their discharge was delayed. The hospital bed base was almost full and patients had been held in the emergency department overnight. We assessed how these operational pressures, which were fairly typical during the winter months, were managed and what impact the pressures had on patient safety and patient experience.

During our inspection we visited the emergency department, including the emergency decision unit. We visited escalation areas and some inpatient wards, where outlying patients were accommodated. We spoke with staff and patients in these areas and looked at some patients' records. We also attended bed meetings so that we could assess how the trust was managing patient flow. Our visit provided us with only a snapshot of performance so we looked at recent historical performance data and other information provided by the trust to provide a fuller picture.

Summary of findings

We did not rate this service because of the limited focus of this inspection. We looked at specific key lines of enquiry under three of our five questions; is the service safe, responsive and well led?

We found:

- The trust's escalation status during the months of December 2017, January and February 2018 indicated that they experienced significant and extreme operational pressures, due to insufficient capacity to meet demand for services, for much of this time. This put patients at risk.
- The trust's winter resilience plan had not been effective and had not yielded the required capacity and flow to manage the significant pressures the trust faced during the winter months.
- The emergency department was frequently crowded; patients were cared for in corridors and in ambulances outside the emergency department. Patients experienced delays in their assessment, treatment and admission to a hospital bed.
- There were frequent delays in ambulance staff handing over care of patients to emergency department staff. This included a significant number of delays of over one hour, known as black breaches, and ambulance staff being unable to offload their patients. This not only delayed patients' assessments in the emergency department, but also delayed ambulance staff who were not available to respond to further calls.
- Patients were not always promptly assessed on arrival in the emergency department to identify or eliminate any serious or life threatening illness or injury. Processes to stream and triage patients on their arrival in the emergency department were not operating efficiently or effectively.
- We could not be assured that patients in the major treatment area of the emergency department were regularly monitored to ensure their on going safety and comfort.

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- Patients experienced lengthy delays in the emergency department. The trust was consistently failing to meet the national standard which requires that 95% of patients are admitted transferred or discharged within four hours.
- A significant number of patients waited up to 12 hours in the emergency department from the time a decision was made to admit them to the time they were admitted. The trust's performance was significantly worse than the England average.
- The emergency department was not adequately staffed at night. The department had assessed that two middle grade doctors were required at night but currently night time cover was provided by only one. Junior medical staff felt unsupported and vulnerable at night and consultant staff were frequently working additional hours to support their junior colleagues. It was felt that this was not sustainable.
- Patients were frequently accommodated in corridor areas of the emergency department, when all assessment and treatment areas were full. These areas were not suitably equipped and did not facilitate easy monitoring of patients held there. Queuing caused congestion, which hampered the movement of patients, staff and equipment in these areas. Despite the efforts of staff, patients' comfort, privacy and dignity needs could not be met.
- Inpatients were frequently cared for in unsuitable outlying areas of the hospital. This meant they were admitted to a ward in a speciality other than that which they were assigned to. We could not be assured that staff caring for these patients had the necessary skills and experience to meet these patients' needs.
- Patients were frequently cared for in departments (designated as escalation areas), which were not designed, equipped or staffed for inpatient care.
- There was a lack of effective governance to provide assurance that escalation areas were being used in a safe and appropriate way.

- The regular and frequent use of day case departments as escalation areas impacted on their 'business as usual' activity, their ability to function efficiently, and resulted in some elective day case procedures being cancelled.
- Escalation areas were often staffed by temporary staff and we could not be assured that they had the required skills and experience to care for the patients admitted there.
- Escalation areas were not suitably designed or equipped for inpatient care. A lack of facilities presented challenges for staff to provide to meet patients' basic care needs.
- Patients experienced frequent bed moves, often at night, which impacted on their comfort and wellbeing.

However:

- There was focus and drive to improve performance. There were many streams of work on going to improve patient flow and operational performance but plans were not fully developed and changes not embedded.
- There was evidence that staff in the emergency department consistently used a screening tool to identify suspected sepsis and followed guidance to ensure prompt treatment.
- Patients attending the emergency department with acute mental illness were assessed using a recognised mental health risk assessment. The trust monitored compliance with this and had performed at above 90% since November 2017.
- There was a dedicated discharge ambulance, which had been funded from December 2017 through to March 2018, which staff told us was very helpful in facilitating patient discharges and improving patient flow.

Urgent and emergency services

Are urgent and emergency services safe?

Not sufficient evidence to rate

We found:

- Systems to assess risks to patients and monitor their safety were not effective.
- There were frequent delays in ambulance staff handing over care of patients to emergency department staff. This included a significant number of delays of over one hour, known as black breaches, and ambulance staff being unable to offload their patients. This not only delayed patients' assessments in the emergency department, but also delayed ambulance staff who were not available to respond to further calls.
- Patients were not always promptly assessed on arrival in the emergency department to identify or eliminate any serious or life threatening illness or injury. Processes to stream and triage patients on their arrival in the emergency department were not operating efficiently or effectively.
- We could not be assured that patients were monitored with the required frequency in the major treatment areas of the emergency department. The safety checklist, designed to prompt staff to undertake hourly checks and tasks, was not consistently completed and there were no effective systems to monitor how consistently these checklists were used.
- The emergency department was not adequately staffed by doctors at night. The department had assessed that two middle grade doctors were required at night but currently night time cover was provided by only one. Junior medical staff felt unsupported and vulnerable at night and consultant staff were frequently working additional hours to support their junior colleagues. It was felt that this was not sustainable.
- There was heavy reliance on temporary nursing staff in order to provide the staffing levels and skill mix which had been assessed as required to provide safe care.
- Patients were frequently cared for in non-clinical areas of the emergency department, which were not equipped for patient care. These areas were not suitably

equipped and did not facilitate easy monitoring of patients held there. Queuing caused congestion, which hampered the movement of patients, staff and equipment in these areas.

- Patients were frequently cared for in unsuitable 'outlying' areas of the hospital. This meant they were admitted to a ward in a speciality other than that which they were assigned to. We could not be assured that staff caring for these patients had the necessary skills and experience to meet these patients' needs.
- Patients were frequently cared for in departments such as day care units, endoscopy and theatre recovery (designated as escalation areas) which were not designed, equipped or staffed for inpatient care. There were not effective governance processes to provide assurance that these departments were being used in a safe way.

However:

- There was evidence that staff in the emergency department consistently used a screening tool to identify suspected sepsis and followed guidance to ensure prompt treatment.
- Patients attending the emergency department with acute mental illness were assessed using a recognised mental health risk assessment. The trust monitored compliance with this and had performed at above 90% since November 2017.

Environment and equipment

- Patients were not always cared for in a safe environment.

Emergency Department

- The design and layout of the emergency department did not keep people safe.
- The layout of the emergency department had been reconfigured over time to create more capacity but the size of the department and physical separation of the two major treatment areas did not readily allow good communication and oversight of the department as a whole. Senior staff had radio contact with one another but communication remained challenging.
- Senior staff told us the four-bed resuscitation was too small. When this area was full, patients were seen in the

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major treatment area (the department tried to keep a major cubicle free for life-threatening emergencies) or they were seen in the star suite, located just inside the ambulance entrance and opposite the resuscitation room. This room was not suitably equipped for this purpose and it was used for multiple purposes, including the transfer of patients from an ambulance stretcher to a hospital trolley.

- When all assessment and treatment areas in the emergency department were full, and escalation within the wider hospital had not facilitated any further transfers, patients were held in corridors. These were not clinical areas and were not suitably equipped for patient care. There were no call bells, piped oxygen and suction and nowhere to safely secure patients' records.
- Up to six patients could be held in the corridor just inside the ambulance entrance, outside the area known as pit stop. We observed patients waiting in this area during our inspection. Not all patients in this area could be easily observed by staff as the corridor extended around the corner. We observed that when patients queued, this area became congested, which hampered movement of patients, staff and equipment.
- Following our inspection the trust told us that they were exploring options to improve physical capacity for ambulance handovers. A plan was to be agreed by the end of April 2018 and to be implemented prior to next winter.
- According to the trust's Full Capacity Policy (February 2017), in extreme circumstances (defined as an internal critical incident), further capacity was created by holding suitable patients, who had been assessed and were awaiting admission, in the corridor between the emergency department and the acute medical unit. We did not observe this during our inspection but senior staff told us this was a frequent occurrence.
- A further step, when an internal critical incident had been activated, was to 'cohort' incoming patients, following triage in the corridor between the minor treatment and the children's areas. Again, we did not observe this during our inspection. In December 2017 staff reported numerous concerns, via the incident reporting procedure, regarding the use of the 'cohort corridor' area:
 - On 26 December 2017 a staff member reported patients were cared for by ambulance staff in this area for many hours (in excess of eight for one patient).
 - On 27 December 2017 a staff member reported that a patient who attended the emergency department with chest pain was cared for in this area for more than four hours, during which time an ECG was not performed. The incident was classified as a 'near miss' as the patient came to no harm. However, it was acknowledged that an ECG should have been performed within 10 minutes of arrival. This was challenging to achieve in corridor areas because patients' privacy and dignity could not be maintained.
 - On 27 December 2017 a staff member reported not being able to support a bed-bound patient who required assistance with toileting as this would require taking the patient to another area of the department, leaving four other patients unattended.
 - On 28 December 2017 a patient with sepsis was cared for in this area and their treatment was delayed by four hours.
 - On 30 December 2017 a staff member raised concerns about the inappropriate use of the area to care for sick elderly patients who had been on trolleys for hours. They were not able to transfer them to beds because of a lack of space, unable to check pressure areas or assist patients with toileting because of a lack of privacy. They complained of no emergency equipment, such as oxygen and suction, and nowhere to wash their hands. They also raised concerns that there was no telephone in the area or other communication system.
 - On 30 December 2017 a staff member raised concerns that they were unable to pass through this area to transfer a child to the children's assessment unit, because the corridor was blocked by patients on trolleys and one on a hospital bed. It was highlighted that this was a risk in the event of a fire.
 - On 16 January 2018 a staff member raised concerns that a patient receiving palliative care was cared for in this area. The patient was delirious and attempting to climb out of bed. A female patient on a trolley was taken to a male toilet for care.
- In response to these concerns, the trust revised the full capacity protocol and stressed that the area was to be used in extreme circumstances only (when 10 ambulances were being held). Despite this being described as an action taken in exceptional

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circumstances, the trust was not able, for “data capture reasons” to provide data which showed how many times this had occurred in the last three months. They estimated that this had occurred on 10 to 15 separate occasions during this period.

Escalation areas

- The trust had designated a number of areas within the hospital as escalation areas. These were departments which had not been designed for overnight stays but accommodated patients when the hospital was under extreme pressure for beds.
 - In the cardiac day unit there was a daily checklist in use, which included environmental checks. This was not evident in other escalation areas. We could not therefore be assured that environmental risk assessments had taken place or that there were adequate governance arrangements in place to ensure the ongoing suitability of these premises and whether they were suitably equipped. Our observations in some of these areas indicated there was a lack of oversight in regard to environmental issues.
 - Most of the escalation areas did not have a call bell system to enable patients to summon help from staff. Some, but not all patients, accommodated in these areas had been given hand bells for this purpose.
 - The theatre recovery unit regularly accommodated patients overnight. Patients and staff told us it was cold in this department. Staff had access to portable heaters but had not considered the risks of using these heaters, such as the risk of patients tripping over leads or the risk of burns.
 - In the acute medical unit (pink zone) we noted there were three boxes of unsecured medicines on top of the resuscitation trolley. This was unsafe in an unsecured area, with a high volume of people through the area.
 - In several areas we noted hand gel dispensers were empty.
- ## Assessing and responding to patient risk
- Systems to assess risks to patients and monitor their safety were not effective.
 - There were frequent delays in ambulance staff handing over care of patients to emergency department staff. Handovers were delayed by 30 to 60 minutes as follows:

- November 2017: 64
- December 2017: 545
- January 2018: 453
- In the same period many patients were delayed by over an hour. This is known as a black breach. There were 339, 642 and 461 black breaches reported in each month respectively. This performance improved slightly in February 2018, with 324 breaches reported.
- Staff told us that patients were frequently held on ambulances outside the emergency department because there was no capacity to receive them. This not only delayed patients' assessments in the emergency department, but also delayed ambulance staff, who were not available to respond to further calls. This did not occur during our visit and we saw patients were being offloaded from ambulances in a timely manner. We requested data from the trust to quantify this issue but they were unable to provide this.
- We noted there was a lack of consistency in the way in which the ambulance handover process was completed. Some staff completed a full handover, including a visual assessment of the patient. Others did not visually assess patients, who had already been moved to a corridor space. They recorded only a patient's surname and the location of the patient in the corridor. This high risk approach could result in patients being wrongly identified, particularly if they were confused or unable to confirm their name.
- Processes for streaming and assessing patients on arrival in the emergency department were in line with guidance issued by the Royal College of Emergency Medicine (RCEM); however at times of surge, they were not operating efficiently and assessments were sometimes delayed. RCEM recommends that systems identify the most time-critical patients for treatment and prioritise the rest.
- There were streaming and triage systems in place for both ambulance-borne and self-presenting patients. Streaming is a recognised system to allocate the patients to the most appropriate location and the correct person to manage their needs. Triage is a process of initial assessment which is described by

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RCEM as a system which sorts patients according to a combination of their presenting complaint and measured physiological parameters at the time of arrival in the emergency department.

- The Royal College of Emergency Medicine recommends that patients should be assessed by a healthcare professional within 15 minutes of arrival. In the period November 2017 to January 2018 the percentage of patients arriving by ambulance who were assessed within 15 minutes was as follows:
 - November 2017: 79%
 - December 2017: 76%
 - January 2018: 75%
- Patients arriving by ambulance were handed over to a streaming nurse, who directed the patient to the appropriate part of the department. Patients identified as requiring assessment and treatment in the major treatment area were taken to an area known as the pit stop, located just inside the ambulance entrance. This area had six trolleys and four chairs for ambulant patients. The area was staffed by a team of nurses and healthcare support workers 24 hours a day and between 8am and 10pm there was a senior decision-maker (consultant, ST4 or consultant nurse). The team was responsible for undertaking an initial assessment and ordering appropriate investigations, before streaming and moving patients to the appropriate part of the emergency department or acute medical unit ambulatory clinic. The aim was for a rapid assessment and throughput of patients, ideally within 20 minutes, in order to maintain flow in the emergency department. This system, known as rapid assessment and treatment is also recognised by RCEM as one which improves efficiency by ensuring that patients do not wait unnecessarily for investigations or diagnostic decision making.
- We observed that patients remained in the pit stop for up to 45 minutes, while new incoming patients were assessed in the corridor. When we discussed this with the chief of service they acknowledged: “it has to be a slicker process.” They felt that the efficiency of this process was dependent on the clinicians working in this area and there were varying working styles and practices. The chief of service confirmed that the process had not been audited since its introduction approximately 16 months ago due to time constraints.
- If the pit stop was full, up to six patients could be held in the corridor area outside the pit stop. There were occasions during our inspection, when there was a surge in ambulance arrivals, and the pit stop became full but there were care spaces available in the major treatment areas. According to the Pit stop Policy, in these circumstances, additional medical and nursing staff would be identified to support the pit stop area. This was known as ‘pit stop surge’. On the day of our inspection, the pit stop was frequently full, leading to congestion in the area surrounding it. We did not see additional staff assigned to the area but we saw the nurse in charge assisting to identify and move suitable patients to the major treatment areas.
- Patients who self-presented to the emergency department were seen on arrival by a registered nurse, known as the navigator. Their role was to quickly assess patients in order to direct them to the most appropriate area of the emergency department. This may be the minor or major treatment areas or the GP-led urgent care area. There was no policy or standard operating procedure which described this process but we were advised that the process was based on a recognised streaming model. There was a flow chart, showing the streaming options and, following our inspection, this was incorporated into a standard operating procedure. This included inclusion and exclusion criteria and mitigation steps in the event of high demand. We were concerned that this process was not operating efficiently or effectively; this had not been audited since its introduction approximately 12 months ago.
- We asked the trust to provide data to show the percentage of self-presenting patients assessed within 15 minutes. They responded to say that the navigator assessed patients on arrival. They told us “On occasions some patients may have to wait (this is not monitored) to see the Navigator when there is more than one person arriving at the same time.” We could not therefore be assured that this system was effective or safe.
- The waiting room had been ‘divided’ by the use of red and blue floor covering to separate those patients who were waiting to be assessed, and those who had been assessed and were waiting for treatment. There was signage to direct patients on arrival to sit in the area designated ‘red’, where they would wait to be seen by

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the navigator. Following their initial assessment, patients were given a numbered ticket and asked to sit in the blue area of the waiting room where they would be called by the receptionists to register their details. They would then wait to be called by the appropriate clinician for their treatment to begin.

- The navigator's base was a glass screened room, which enabled the nurse to observe the waiting room. However, the positioning of the 'red' seating, just inside the entrance, meant that patients could not be easily observed by either the navigator or the reception staff. Staff told us that sometimes patients queued outside the entrance because all chairs were taken. This prevented staff making a visual assessment of patients who may require urgent attention.
- Although the role of the navigator was described to us as a streaming nurse, we observed that a full initial assessment (triage) took place for some patients, including a set of observations and administration of pain relief. The registered nurse was supported by a healthcare assistant, who was able to undertake some investigations. While this was appropriate for individual patients, it did not enable the nurse to have an overview of, or quickly assess patients in the queue, who had not even been seen by a receptionist. When we discussed this with the chief of service, they told us that when initial assessment was delayed and patients were queuing, additional staff would be deployed to this area. We observed on several occasions during our inspection that the 'red' seating area was full and we were not assured that the navigator was able to assess what was in the queue. Meanwhile, the receptionists were not occupied.
- Patients identified by the navigator as requiring assessment and treatment in the major treatment area were directed/escorted there immediately or, if the pit stop was full, asked to sit in one of four numbered chairs at the back of the waiting room, where they could be easily observed by staff.
- There was a system in place for the ongoing monitoring of risks to patients in the emergency department so that staff could identify seriously ill and deteriorating patients. However, we could not be assured that staff consistently adhered to this system. The emergency department used a nationally recognised 'track and trigger' system to identify critical illness or deteriorating patients. The streaming nurse or other receiving nurse was required to record patients' observations, as recorded by the ambulance crew, and undertake a first set of emergency department observations and calculate an early warning score.
- The emergency department had recently (November 2017) introduced a safety checklist. This was a time and sequence-based checklist of prompts and tasks, which should be completed every hour for all patients in the major treatment areas, from their first assessment to discharge or transfer to another team. It included a prompt for the identification of sepsis. The checklist had been introduced in paper format, although there were plans for this to become an integral part of the electronic record. It replaced an intentional rounding tool, which formed part of the electronic record and we were told that there remained some confusion amongst staff as to which tool should be used. We asked the trust to explain how the new tool had been introduced and communicated to staff; they told us it had been communicated via email. They told us that one audit had taken place since its introduction. This was a snapshot audit of 18 patient records. One record was discounted because the patient was treated in the resuscitation room. Eleven out of the remaining 17 patient records had a safety checklist present. Seven out of the eleven checklists had no sections completed; the remaining four had one section completed. Despite this extremely poor compliance, no further audits had taken place, until we raised concerns during our inspection about this checklist not being used consistently. The trust subsequently informed us that daily audits had taken place since our inspection but they did not share any findings with us.
- We checked a sample of (paper) patient records. We found that the safety checklists were not consistently completed to provide assurance that patients were regularly monitored. We were not able to check the electronic records for evidence that the intentional rounding tool had been used to record patient monitoring, except for patient 9 (see below). We found:
- Patient 1 had a set of physiological observations undertaken and a NEWS score calculated on arrival in

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the emergency department. We reviewed their records three hours and 45 minutes later in the major treatment area. No safety checklist had been completed at this time.

- Patient 2: We reviewed their records when they had been in the emergency department for four hours. The safety checklist had been completed for the first hour only.
- Patient 3: We reviewed their records when they had been in the emergency department for three hours and 15 minutes. The safety checklist had been completed for the first hour only.
- Patient 4: We reviewed their record when they had been in the emergency department for 57 minutes. The safety checklist had been completed for the first hour.
- Patient 5: We reviewed their records when they had been in the department for more than eight hours. The safety checklist had been completed five times.
- Patient 6: We reviewed their records when they had been in the emergency department for three hours and 30 minutes. The safety checklist had been completed four times.
- Patient 7: We reviewed their record when they had been in the emergency department for more than four hours. The safety checklist had been completed four times.
- Patient 8: We reviewed their record after four hours and 30 minutes in the emergency department. The checklist had been completed in the first hour only.
- Patient 9: We reviewed their record when they had been in the emergency department for 10 hours. Physiological observations and a NEWS score had been recorded on arrival and sporadically (five times) thereafter. This was despite having NEWS scores of between three and eight during this time. No observations had been recorded for the last one and a half hours, despite a NEWS score of 5. There were no other nursing interventions recorded. We discussed this with the nurse in charge who told us that some staff were continuing to use an intentional rounding tool, which formed part of the electronic patient record. We checked this and it had not been completed. We could not therefore be assured that this patient received regular monitoring of their safety and comfort during their extended stay in the department.

- Following our inspection the trust informed us that daily monitoring of the safety checklist had been introduced, to be overseen by two newly appointed matrons, reporting to the Chief Nurse.
- The service used a screening tool to identify suspected sepsis. There was a prompt on the paper record completed by the streaming nurse in the emergency department. This directed staff to complete the electronic-based sepsis screening and intervention tool. Similarly, the navigator was prompted to consider the possibility of sepsis in self-presenting patients and where sepsis was indicated, patients would be transferred to the major treatment area.
- Performance against standards in relation to the timely identification and treatment of sepsis in patients attending the emergency department or direct admission units in the period October to December 2017 was as follows:
 - 98% of patients were screened for sepsis (against a target of 90%)
 - 80% of eligible patients with sepsis were treated within one hour (against a target of 90%).
- Patients attending the emergency department with acute mental illness were assessed using a recognised mental health risk assessment. The trust monitored compliance with this and had performed at above 90% since November 2017.
- There was a psychiatric liaison service, provided by the local mental health trust from 8am until midnight, seven days a week. The team provided support to clinicians in the assessment and management of patients (aged 16 years or over) presenting with mental health problems. It was identified in the trust's Winter Resilience Plan 2017/18 that there was "increased pressure from mental health attendances and slow movement into psychiatric beds". The plan did not outline how this was to be addressed in the current year, although it reported the employment of a mental health nurse, 24 hours a day, seven days a week on the emergency decision unit. This in some part addressed the concerns we raised at our previous inspection in relation to the supervision of mental health patients but the role of this nurse was not to undertake mental health assessments; this was the responsibility of the psychiatric liaison service.

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- The service specification for the psychiatric liaison service (dated 28 July 2017) stated that the service would work towards providing a response to referrals for patients in the emergency department within one hour (within their operational hours). The specification stated that this standard did not form part of agreed formal key performance indicators but was recorded for monitoring purposes. We requested performance data in respect of this standard. The trust told us they did not hold this data as this service was commissioned by the clinical commissioning group and monitoring was undertaken by them. The lack of this data indicated that the trust was not proactively managing this issue which impacted on patient flow.

Escalation; managing crowding in the emergency department

- There was an overarching Trust Capacity Management Policy (last reviewed and updated in January 2018). This document set out the steps to be taken in order to minimise the risks associated with operational pressure caused by a surge in demand for services.
- There was a Full Capacity Policy (February 2018) which set out the steps to be taken to address crowding in the emergency department. The policy stated: "When the ED has reached its maximum number of patients (or is rapidly approaching its maximum), safety of the patients and staff is at risk. When the ED is at OPEL four escalation status, normal functioning of the department is not possible." The OPEL (operational pressures escalation level) framework is a national system which allows operational pressures to be measured consistently by healthcare organisations, using a set of agreed definitions. The Full Capacity Protocol was activated when the trust or the emergency department's status was at OPEL three (major pressures compromising patient flow), approaching OPEL four (organisations unable to deliver comprehensive care).
- The trust's escalation status was OPEL three or four on 80 out of 90 days from December to February 2018 (every day in January 2018). OPEL four was declared on 41 days in this period.
- There were a number of criteria, which, if met, would trigger the full capacity policy to be implemented. This was linked to the OPEL status. Triggers in the emergency department included:
 - More than 15 patients in the emergency department waiting for an inpatient bed
 - Five patients have exceeded eight hours in the emergency department from arrival
 - Risk of breaching 12 hour trolley wait standard (no patients should wait more than 12 hours from the time of decision to admit to the time they are admitted)
 - No care space in the emergency department and patients starting to queue in the ambulance arrival area
 - More than six ambulances being held for more than 30 minutes.
- The Full Capacity Protocol set out a series of actions, including risk assessment, to facilitate the safe and appropriate transfer of patients in the emergency department to beds on the acute medical unit or directly to a speciality ward by opening an additional bed space on certain wards (going one up) and/or vacating a bed by moving a patient (expected to be discharged within four hours) to a seating area or discharge lounge (stepping down).
- The policy set out further actions in the event that one up/step down actions do not create enough capacity to improve safety in the emergency department and there are more than 10 ambulances being held for more than 40 minutes. These steps are:
 - Cohort and hold in the acute medical unit (AMU) corridor suitable (clinically stable) patients for transfer to AMU or from AMU to a speciality ward.
 - Out of hours only, cohort patients on arrival in the emergency department, and following triage, hold in the corridor between the minor treatment area and the children's area. This step and the staffing arrangements (ambulance staff and/or trust nurses) had to be agreed with the consultant and nurse in charge of ED and a director from the trust and the ambulance service.
- There were systems in place to ensure that senior staff in the emergency department maintained oversight of the number and acuity of patients in the emergency department and that risks associated with crowding were escalated to the site management team so that the full capacity could be activated.
- There was nurse in charge of the emergency department, including the emergency decision unit, on every shift. There was also a nurse in charge of each of the two major treatment areas and the minor treatment

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area. These staff were sometimes supported by an administrative assistant, known as a tracker, who was able to undertake tasks to facilitate patient transfers to wards, such as printing patients' records, chasing test results and liaising with staff on the wards. However, this role was not consistently filled on all shifts due to vacancies.

- The nurses in charge were in regular contact with each other and with the acute medical unit coordinator, 'silver control' nurse in charge and the site management team via radio link.
- There was a board round at 7am, attended by the night time site manager and the silver control nurse in charge. The nurse in charge also attended the doctors' handover at 8am.
- There were regular bed management (operations) meetings throughout the day, attended by the nurse in charge (silver control).
- At the 8.30 am meeting the team reviewed the effectiveness of the previous day's planning and actions allocated to improve efficiency for the next 24 hours. At 11 am there was a review of actions that should have been completed, such as discharges and bed moves. The 6pm the meeting focused on outstanding discharges, bed moves, and available beds, with the aim of having 10 medical and six surgical beds to provide capacity for overnight admissions via the emergency department. The escalation areas were identified and the number of beds in each area agreed. Both medical and nurse staffing were reviewed and risk assessed, with any specific areas of concern noted, and agreed actions allocated to specific staff.
- The aim of this planning was to facilitate flow by ensuring staff were aware of available capacity and resources. However, we noted that agreed actions were not always completed in a timely manner and changes to the plan, such as the decision to create extra bed capacity on the gynaecology ward overnight, were not effectively communicated or documented. It was unclear the following morning, who approved this or why the site team were not aware of this.

Use of escalation areas

- The Capacity Management Policy identified that in order to accommodate a surge in demand, inpatients could

be accommodated in 'outlying' wards. Outliers are patients placed on wards in a specialty other than the one they are assigned to. In November, December 2017 and January 2018 there were over 3,200 outliers in each month.

- The policy further set out the arrangements for opening escalation areas. These were hospital departments which do not usually accommodate inpatients.
- Departments which were regularly used in this way included the theatre recovery area, the renal day unit, the acute oncology service, endoscopy, emergency ambulatory care and the pink zone in the acute medical unit. Data provided by the trust showed that escalation areas had accommodated patients every day for the last three months, with daily numbers ranging from five to 65 patients.
- We were not assured that decisions to place patients in these areas were always made based on a proper assessment of the patient's suitability and the capacity and capability of the departments receiving these patients.
- We were told that all outliers had a risk assessment completed, and this would be held locally in a specific folder. This was to ensure they were suitable to be moved to an outlying ward. Compliance with this process had not been audited. Staff told us there were plans to audit this but this step was not documented in the escalation policy and there was no timescale for the audit to take place.
- Staff in the theatre recovery area, which was regularly used as an escalation area, told us there was a standard operating procedure for use of this area for escalation but they were unable to confirm its status or how it had been communicated to staff. There were no governance arrangements for this or other escalation areas to provide assurance that they were being used appropriately and that they were properly resourced and equipped. Following our inspection the trust informed us that a record of generic risk assessments for each escalation area opened would be kept in a file in the operational centre and risk assessments for individual patients allocated to these areas would be kept in the relevant patient's record. They acknowledged that this required review and more effective management. They told us that the trust's

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medical director and chief nurse were working on a trust wide risk assessment protocol for use of escalation capacity and for the risk based identification and safe management of individual patients allocated to escalation areas. This was to be completed by mid-April 2018.

- Staff in theatre recovery told us there was a screening tool used to risk assess patients' suitability for transfer to an escalation area. This was not always completed. There was a handover sheet which stated the reason the patient was suitable and contact details for the speciality they were in the care of. The agreed process for selecting patients suitable for overnight stay in recovery was to review theatre lists in the morning to identify suitable patients. These were usually patients who were likely to be discharged the following morning. However, staff told us that sometimes decisions were taken late in the day which made it problematic in terms of informing patients and relatives and ensuring the appropriate staffing levels.
- Staff confirmed that speciality doctors reviewed patients in recovery each morning; although they said they sometimes had to chase doctors to review patients and prescribe any take home medicines.
- Staff on the renal day unit told us there was a screening process for outliers to be admitted to the unit, but they felt that this was mostly not adhered to and was frequently over-ruled. A number of incidents had been reported by staff where they had concerns about the suitability of patients, the capacity of the department and the impact on their 'business as usual' activity. The length of stay on the unit was supposed to be 24 to 48 hours. Staff told us patients could remain in the unit for a week, which suggested the screening and selection process was not effective.
- Staff we spoke with on the acute medical unit (pink zone) were not knowledgeable about the patients in their care. They told us that some patients had no treatment or care plan, despite being on the unit for several hours, following transfer from the emergency department. We looked at the records for two patients who had been admitted to the acute medical unit at 12.15 am and 5am. These patients were still waiting to be clerked and a treatment plan put in place at 10.30 am.

Nursing staffing

- The service did not consistently have enough staff with the right qualifications, skills, experience and training to keep patients safe from avoidable harm and abuse, and to provide them with the care and treatment they needed.

Emergency department

- Senior staff in the emergency department told us that nurse staffing levels and skill mix had recently been reviewed and there was a business case pending for a further 10 registered nurses and additional healthcare support workers. The department was routinely aiming to staff up to the target levels using bank and agency staff. We were told that the emergency department target staff to patient ratio was one registered nurse to four patients in the major treatment areas. Staff told us this was more often one to five. There was a shortage of healthcare support workers and gaps were regularly filled by bank or agency staff.
- Following our inspection the trust confirmed that the business case to increase the nurse staffing establishment was to be presented to the executive management team in April 2018. They also confirmed that two new matrons had been appointed at the end of March.
- Medical staff told us they had concerns about the lack of registered children's nurses overnight. We asked the trust to provide data to demonstrate the percentage of shifts which were filled by a registered children's nurse or an adult trained nurse with additional competencies to care for sick children. They did not routinely report on this; however they confirmed there had been two occasions in the previous six weeks when there was no registered children's nurse on duty at night. They told us, in these circumstances sick children would be transferred directly to the children's assessment unit, although injured children would continue to be brought to the emergency department and the registrar for paediatrics would be called to attend the emergency department.
- There was a registered general nurse and a healthcare assistant employed on the emergency decision unit, supported by a registered mental health nurse (RMN) 24 hours a day, seven days a week.

Escalation areas

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- We were not assured that all escalation areas and wards accommodating medical outliers were appropriately staffed to ensure patient safety.
- The renal day unit (RDU) was staffed by bank and agency staff at night and at weekends as RDU staff were contracted to work weekdays only. We looked at a sample of staff used in the last month which showed the unit did not employ regular staff. Staff told us they could not influence who was admitted to this unit; this was decided by the hospital's bed manager and patients were assigned to a mix of medical specialties. This meant some staff may not have the skills or experience to care for these patients. There was a one page induction checklist but it was not clear who oversaw this to ensure that staff were adequately inducted.
- The theatre recovery area was staffed by one registered nurse and one healthcare assistant for seven patients. This was increased to two registered nurses if patient numbers increased up to nine, sometimes 11 patients. The area was primarily staffed by temporary (bank and agency) staff, although we were told that the service tried to avoid the area being staffed solely by temporary staff. This was achieved by placing temporary staff on surgical wards and releasing a permanent member of staff to work in the escalation area.
- The cardiac day unit (CDU) was proactively managing the use of this department as an escalation area and had recently developed a standard operating procedure (this was still in draft), which set out patient eligibility and exclusion criteria. The area could only be used to accommodate cardiac patients so they could be assured that the staff had the necessary skills and experience to care for these patients. The department maintained a daily staffing sheet which detailed the skills of the staff responsible for the care of patients in this area. The escalation area on CDU was consistently staffed by a permanent member of nursing staff. If agency nurses were used in support, they received an induction and they were assessed for their competence to deliver cardiac care.
- We visited the gynaecology ward, where on the second day of our inspection, we found that four additional patients (medical outliers) had been accommodated overnight. Staff told us that since August 2017, 10 beds had been designated for frail elderly patients. Staff told

us that not all staff had the necessary skills and experience or confidence to deal with this group of patients. They told us they were encouraged to develop these skills by attending study days.

Medical staffing

- There were not enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Senior and junior doctors expressed concerns about medical staffing levels in the emergency department at night. Senior medical cover at night was provided by a registrar or middle grade doctor, supported by a consultant on call. This was universally felt to be inadequate. Junior doctors felt vulnerable and consultants felt obliged to stay late in order to support their more junior colleagues. There was a funded establishment for 12 whole time equivalent (WTE) middle grade/registrar doctors, with 11.8 WTE in post. A further four WTE were required to increase cover to two middle grade doctors at night. There was a business case pending to increase the establishment. In the meantime, there was a standing request for locum cover at this level but this was not able to be filled.
- The chief of service expressed concerns about the frequency of late finishes for consultants. They told us that consultants had been completing exception reports since December 2017 to highlight this problem. This identified that 60 additional hours were worked in the month of December 2017. Consultants were also, on occasions, filling gaps in the junior doctors' rota by 'acting down'. The chief of service felt the level of additional hours was not sustainable and he expressed concerns about the wellbeing of some colleagues.
- Specialty trainees (year 3) told us they were required to work one in two weekends and they were concerned about work: life balance. They also told us they had insufficient time to devote to their continuing professional development.
- Following our inspection the trust updated us on the steps taken to increase the number of senior clinicians in the emergency department. Three advanced care practitioners had been recruited, to start work in April 2018. A business case for 2.8 WTE additional consultants had been approved and recruitment was to begin in

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April. There were also plans to recruit a further four middle grade doctors and a more attractive rewards package was being developed in order to attract applicants for this role which was traditionally difficult to fill.

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

Not sufficient evidence to rate

We found:

- Patients were not able to access care in a timely way or in the right setting.
- The trust was consistently failing to meet national standards in relation to the time patients spent in the emergency department, the time they waited for treatment to begin and the time they waited for an inpatient bed.
- Facilities and premises were not appropriate for the services delivered. Demand for services frequently outstripped the availability of appropriate clinical spaces to assess, treat and care for patients.
- In the emergency department, patients frequently queued in the corridor, where it was difficult to maintain their comfort, privacy and dignity.
- Inpatients were frequently cared for in unsuitable settings, sometimes in areas which were not designed for inpatient care. This meant it was challenging for staff to maintain basic standards of care, including the provision of single sex accommodation.
- The frequent use of escalation areas had a knock on effect in terms of the efficient functioning of those departments and had led to elective surgery and day case procedures being cancelled.
- Operational and capacity pressures within the hospital resulted in many inpatients being moved, in order to accommodate new patients. These moves often occurred at night

However:

- There was a dedicated discharge ambulance, which had been funded from December 2017 through to March 2018, which staff told us was very helpful in facilitating patient discharges and improving patients flow.

Service planning and delivery to meet the needs of local people

- Facilities and premises were not appropriate for the services delivered. Demand for services frequently outstripped the availability of appropriate clinical spaces to assess, treat and care for patients.
- In the emergency department, patients frequently queued in the corridor, where it was difficult to maintain their comfort, privacy and dignity. Data provided by the trust showed that between 23 January 2018 and 28 February 2018, a total of 1596 patients spent more than 15 minutes in the ED corridor. Daily, this ranged from six to 66 patients.
- During our inspection we saw patients queuing on trolleys in the area around the 'pit stop', just inside the ambulance entrance to the emergency department. Staff had taken steps to restrict access to ambulance crews by placing temporary screens just inside the ambulance entrance, to prevent a cold draught in the corridor. It was a freezing cold day and this undoubtedly helped to exclude draughts, but the area continued to be cold (staff working in this area wore fleece jackets). However, the screen caused inconvenience to ambulance crews, who were directed to the minors entrance to the department. This meant that patients were wheeled through the main waiting area into the major treatment area, which was not a dignified experience. Ambulance crews arriving with patients who needed to go straight to the resuscitation room were advised to ring a bell to alert staff to remove the screens, although we saw that they simply removed the screens themselves.
- The pit stop was the area designated for rapid assessment and treatment of patients arriving by ambulance. On the day of our inspection, this area was in constant use and patients queued in the corridor, when it became full. When delays occurred, nurses undertook patients' initial assessment in the corridor, where there was no privacy. An overflow room, known as the star suite, with two curtained bays, was used to

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allow staff to perform, for example, ECGs and take blood, allowing patients some privacy. The room was also used by ambulance crews to transfer patients from their stretcher to a hospital trolley.

- We witnessed an elderly patient who spent over half an hour in the corridor. They were confused and had communication difficulties. We saw them raise their arm to attract the attention of a passing nurse. The nurse stopped, reassured them that they had not been forgotten and went on their way. The patient received no attention for the next 30 minutes.

Escalation areas

- Patients were frequently cared for in unsuitable settings, sometimes in areas which were not designed for inpatient care. These were known as escalation areas. This meant it was challenging for staff to maintain basic standards of care, including the provision of single sex accommodation. We did note that staff worked very hard to overcome these challenges. In January 2018 there was a breach of single sex accommodation on the cardiac day unit which had been opened as an escalation area due to extreme operational pressures (the trust was at OPEL 4). The breach affected 10 patients. All patients placed in mixed sex accommodation were immediately spoken with by the nurse in charge and provided with a written apology. These breaches were discussed at regular mixed sex breach meetings.
- On the first day of our inspection inpatients were accommodated in theatre recovery, the cardiac day unit, the renal day unit and the acute medical unit pink zone. These were known as escalation areas. Patients were also often accommodated overnight in the ambulatory emergency care unit, although this was not the case when we visited.
- Seven bays in theatre recovery were regularly used as escalation beds and were in use during our inspection. Staff told us this area had been used for escalation for the last year and in constant use since December 2017. They told us they had accommodated as many as 11 patients. Male and female patients were accommodated in this area, segregated by screens. Patients did not have access to call bells. Staff told us that they provided patients with hand bells but some patients did not have them, although they told us they felt well supported by staff. Several patients complained about the temperature on the unit. One patient told us they had been “freezing” overnight and told us the nurse who took their observations in the morning had been wearing a coat. The trust subsequently advised us that there had been a temporary problem with the heating system and assured us that this had now been repaired. There were male and female toilets and showers were available in another department across a corridor. Staff told us that accommodating patients’ visitors was challenging due to a lack of space. There was access to hot food and drinks for patients, although this was a problem at times as the smell was difficult to tolerate for patients recovering from surgery. Staff told us they did not have enough high tables for patients to take their meals, and they had to borrow chairs from another area if patients wanted to sit out of bed. Patients’ visitors were accommodated for a limited time. Staff commented that it was not appropriate to have visitors in a department where some patients had just come out of theatre.
- We visited the cardiac day unit, which had seven escalation beds. Staff told us that up until December 2017, 14 inpatients were accommodated on the unit. A standard operating procedure had recently been developed, which limited the use of this unit as an escalation area to cardiology patients only and admission to the unit was controlled by a cardiology consultant. Male and female patients were segregated using screens and toilets were switched from male to female or the reverse, using magnetic signs, as required. There was only one shower but patients had access to bathroom facilities on another ward. We spoke with two patients who told us they had no concerns with regard to the mixed sex arrangements or facilities. They told us they felt well supported by staff and had no complaints.
- We visited the renal day unit. Staff told us the unit was in constant use as an escalation area. They told us the unit had been closed to renal day case patients the previous Friday due to being used as an escalation area. They told us it was difficult sometimes to accommodate booked day cases and, on occasions, they had to cancel day case procedures. We spoke with two patients. Both patients had been given a call bell and felt well supported by staff. The unit accommodated only female patients on the day of our visit but staff told us male and

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female patients were accommodated and segregated using screens. There was one toilet and no shower facilities but staff told us they would take patients to wards to use facilities.

- We visited the acute medical unit pink zone. Staff told us this area was in constant use as an escalation area. There were no toilets so patients had to walk outside the unit into the main corridor to access facilities. Staff told us they did not enjoy working here and many staff were leaving the trust.
- Operational and capacity pressures within the hospital resulted in many inpatients being moved, in order to accommodate new patients or in order to cohort, for example male and female patients. There was an increase in moves associated with a spike in flu cases (more than 70) in January 2018. These moves often occurred at night. Between November and January 2018 there were 97, 163 and 116 patients respectively moved for non-clinical reasons between midnight and 7am. During the same period there were over 3000 outliers each month. Outliers are patients who are accommodated on other speciality's wards, for example medical patients are admitted to surgical wards.
- We spoke with one patient who had been admitted to a ward and then woken at 1 am to be moved to the theatre recovery area. They were not very happy about this.
- We visited the gynaecology ward, where, it was reported at the bed meeting, four outlier patients had been accommodated overnight. The knock on effect was that the ward had no emergency beds, as three emergency beds were used, in addition to the rest room for the ambulatory gynaecology clinic. The use of the rest room meant that there was nowhere for patients to rest following procedures undertaken in clinic. This meant that certain procedures could not be undertaken, impacting on waiting times in the clinic. The rest room was equipped with a bed and piped oxygen and suction. However, the room was opposite the clinic waiting room and the patient accommodated there had to walk into the corridor to access toilet facilities. A staff member put screens in place when we raised concerns about this.

Access and flow

- Patients were not always able to access care and treatment in a timely way and in the right setting.

Emergency department

- The trust was consistently failing to meet national standards in relation to the time patients spent in the emergency department, the time they waited for treatment to begin and the time they waited for an inpatient bed.
- The Department of Health's standard for emergency departments requires that 95% of patients should be admitted, transferred or discharged within four hours of arrival. The trust consistently failed to meet this standard. Performance in the period November 2017 to January 2018 was as follows:
 - November: 77%
 - December: 69.7%
 - January: 70.8%
- Patients waited too long for their treatment to begin. The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival in the emergency department to the time that their treatment begins is no more than one hour. The trust's performance against this standard ranged from 59.1% to 63% from November 2017 to January 2018, with the worst performance in December.
- Patients experienced long waits in the emergency department waiting for an inpatient bed. In January 2018 forty-nine percent of patients waited four to 12 hours from the decision to admit to the time they were admitted. This equated to 1250 patients.
- Between November 2017 and February 2018 a total of 148 patients waited more than 12 hours in the emergency department from the decision to admit to the time they were admitted. The worst performing month was January 2018 when there were 73 breaches of this standard. A further two patients waited more than 24 hours. This was much worse than the England average.
- On the first day of our inspection the operations report at 8.30 am reported that the hospital was nearly full and there were 15 patients waiting in the emergency department, with the longest wait at 14 hours. Senior

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staff told us that eleven patients had spent the night in the emergency department. They told us that during the winter months the emergency department had held up to 20 patients waiting for a bed.

- Another key performance metric for emergency departments is the percentage of patients who leave the emergency department before being seen. This is indicative of patient dissatisfaction with waiting times. The standard is that this should be below 5%. In December 2017 performance against this standard was 3.3%.
- The trust was taking steps to improve patient flow by creating additional bed capacity in non-inpatient (escalation) areas. In addition, the trust had temporarily re-designated a ward usually dedicated to elective orthopaedic work which had been used as part of the trust's winter plan for medicine for older people, rehabilitation and stroke. It was reported that the ward would return to its intended designation from 26 February 2018.
- The use of these areas had a knock on effect in terms of the efficient functioning of those departments. The Chief Operating Officer reported to the senior management team in February 2018 a summary of the areas of harm and clinical risk associated with operational pressure and capacity:
- The cardiac day unit (CDU) had been used extensively for non-cardiac medical patients. It was reported that urgent waiting list times for cardiac procedures were "well beyond acceptable or benchmarked waiting times". Three serious incidents had been reported, including one death, all of which were felt to be avoidable if waiting times (two weeks) were maintained. It was reported to the March 2018 board meeting that since mid-February 2018, the use of the CDU as an escalation area was only by negotiation with the on call cardiology consultant and was restricted to cardiology patients only. Staff on the CDU told us there was a doctor's round at 8am to prioritise and plan discharges, to prevent the cancellation of day case procedures.
- It was reported that 34 patients had attended their GP, the emergency department or the acute medical unit because they were unable to access the acute oncology service, which had been closed, due to being in use for escalation beds for 44 days from October 2017 to January 2018.
- The Ambulatory Emergency Care (AEC) unit had been used as an escalation area for most days since late December 2017 reducing its ability to see and assess patients and undertake procedures. It was estimated that 5% more patients had been admitted as opposed to being seen in AEC.
- It was reported that at least 35 gynaecology patients' elective admission had been cancelled in November and December 2017 due to beds being occupied by medical patients. The impact of the closure of emergency bed and treatment rooms was also reported.
- It was reported that surgical procedures and renal biopsies had been cancelled due to the renal day case unit being used for escalation. Twenty-six biopsies were cancelled in January 2018. Staff in the renal day unit told us they had started to report on cancellations due to the department being used as an escalation area. They reported seven cancelled procedures in December and 14 in January 2018.
- It was reported that 249 patients were cancelled in advance of endoscopy procedures during January 2018 due to the requirement to use the endoscopy suite for escalation capacity. Many of these patients were referred via the two-week fast track pathway.
- Following our inspection the trust advised us that the risks identified above had triggered a review of the trust's escalation policy and a plan had been developed to reduce the use of some of these areas, starting with the cardiac day unit, which was now used as an escalation area for cardiology patients only. Elective orthopaedic work recommenced on 5 March 2018. They told us all but 13 urgent day case patients booked before February 2018 had now been seen and treated and they anticipated that the non-urgent backlog would be cleared by the middle of July 2018.
- Other steps to improve patient flow included the provision of a discharge lounge. This department had five beds and 26 chairs, which could be used to accommodate patients, whose discharge had been agreed but who were waiting for discharge arrangements to be completed, for example, take home

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medicines and transport arrangements. The unit was not operating efficiently. Staff told us patients experienced long delays because medicines had not been ordered before they left the ward. Doctors sometimes had to be called to the discharge lounge to prescribe take home medicines or complete discharge summaries, which should have been completed before patients were transferred there. Staff told us patients frequently had to wait several hours for this to be completed and on one occasion a patient had waited five hours. The unit was not properly equipped. There was no hoist and staff frequently had to borrow one from the gynaecology ward.

- There was a dedicated discharge ambulance, which had been funded from December 2017 through to March 2018, which staff told us was very helpful in facilitating patient discharges and improving patients flow.

Admission avoidance

- The emergency department was not the single point of entry to the hospital and there were a number of established alternative pathways. We were told that expected patients, referred by their general practitioner, were admitted directly to the acute medical unit, the surgical admission unit or the fracture clinic. Only patients requiring assessment and treatment in the emergency department resuscitation room would be brought to the emergency department. There were established pathways for fractured neck of femur and acute abdominal illness.
- There was a frailty team, led by a consultant in elderly care, which supported the emergency department from 8am to 8pm, seven days a week.
- The cardiology department had developed a cardiac avoidance project and rapid access clinic. Consultants on the acute medical unit were able to 'pull' appropriate patients from the emergency department, assess them and if appropriate, discharge them home with an appointment to attend the cardiac clinic the following day. The clinic ran from Monday to Friday and saw six patients per day. At weekend, patients would still be admitted.

Are urgent and emergency services well-led?

Not sufficient evidence to rate

We found:

- The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The trust's winter resilience plan had not been effective and had not yielded the required capacity and flow to manage the significant pressures the trust faced during the winter months. We questioned the effectiveness of the plan, the apparent lack of robust challenge and review in the face of failing systems, and whether planning for winter had begun soon enough.
- The trust's corporate risk register did not accurately or fully reflect the serious risks to patient safety and quality arising from operational pressures due to insufficient capacity.
- Appropriate and accurate information was not always available or used effectively to monitor, manage and report on quality and safety. The trust was unable to provide us with key data, which could be used to provide assurance of quality and safety and inform and drive improvements.
- There was a lack of assurance in regard to the effectiveness of safety systems in the emergency department.
- There were insufficient governance arrangements to provide assurance that escalation areas were appropriately used, staffed and equipped.

However:

- There were many streams of work ongoing to improve patient flow and operational performance but the pace of change was slow, plans were not fully developed and changes not embedded.

Governance, risk management and quality measurement

- The trust's winter resilience plan had not been effective and had not yielded the required capacity and flow to manage the significant pressures the trust faced during the winter months.

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- The trust's Winter Resilience Plan, 2017/18 was presented to the board in December 2017. The aims of the plans were to ensure:
 - All patients who are to be admitted have a timely 'decision to admit' to ensure they do not need to remain in the ED for any longer than is clinically necessary
 - Patients are not cared for in hospital corridors
 - Escalation beds have the necessary staffing and equipment to ensure safe care
 - 12 hour trolley waits do not happen
 - Patients do not wait more than 15 minutes in ambulances before being hand over to the hospital
 - The hospital can manage increasing demand because of flu and norovirus.
- The report outlines the predicted bed deficit in the hospital, based on an analysis of demand in the previous winter, and sets out plans to deal with this deficit. It was reported that this would entail the creation of additional bed capacity (additional beds and use of escalation areas) and to improve operational efficiency and performance, through reducing length of inpatient stay and the number of patients who are delayed. There was no efficiency predicted by reducing the number of delayed medically fit for discharge patients, although work was ongoing with system partners to address this.
- Strategic oversight and leadership of the plan was the responsibility of the A&E Delivery Board, chaired by the chief executive, which had identified a 'virtual escalation team' This team was made of senior system leaders and assumed the responsibility of 'gold command', responsible for managing extreme levels of surge and demand (OPEL4).
- There were a number of work streams in progress as part of the unscheduled care transformation programme which ran alongside and supported the winter resilience plan. These included the roll out of the 'SAFER' bundle and 'Red to Green' initiative across the organisation. The SAFER patient flow bundle, developed by NHS Improvement, 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 'red to green' initiative is a visual management system used to identify wasted time in a patient's journey.
- The plan outlined a series of actions to increase bed capacity and flow. These included:
 - Opening of a short stay frailty unit and a temporary increase in beds for medicine for older people, rehabilitation and stroke (MOPRS). This was created by converting an orthopaedic ward to MOPRS.
 - Converting 18 surgical beds to medical beds to allow vascular /medical patients to be cohorted, reducing outliers, and overseen by a dedicated team of medical staff
 - Focus on 'stranded' patients and top 20 delays
 - Hire of an additional scanner over the winter months to provide additional capacity.
 - A mental health nurse to be employed 24 hours a day, seven days a week on the emergency decision unit
 - A new streaming process in ED to be implemented in November 2017 to ensure maximum use of the GP pathway
 - Development of a tracker role to assist nurses in majors 1
 - Additional medical support in ED overnight and weekends (to be provided by locum staff)
 - Early GP assessment in dedicated area in ED with nursing support
 - Work to maximise the use of Ambulatory Emergency Care.
 - The bed management function was to be reviewed and strengthened, roles and responsibilities re-defined and senior presence increased at weekends
 - Establish daily conference calls with systems partners.
- We did not see progress reported at subsequent board meetings against the stated aims and planned actions, but the trust's operational performance in January 2018, reported to the board in March 2018 (Integrated Performance Report), indicated that the winter resilience plan had not been effective, with key national performance indicators not being met. The Exception Report: A&E waiting time standard performance report identified contributing factors; increased ED attendances, the need to isolate and cohort flu patients and the number of medically fit for discharge patients (average 258 per day).

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- A range of actions were reported as being underway to improve patient flow, including further work to extend and embed the use of the SAFER and red to green initiatives. We were concerned about the pace of change. A number of the planned actions were in response to longstanding issues, for example, the employment of additional doctors at night and at weekends. We were told that a business case was being written at the time of our inspection, yet this was raised as an issue at our last inspection. There was no analysis of successes and failures and no timescales for completion of actions which were underway. We concluded there was still significant work to do.
- We considered that the winter plan was instigated too late to effect substantial change over the winter months. The trust acknowledged this and told us the delay was due to personnel changes in the leadership team. They assured us that planning for the 2018/19 winter had begun and the trust was working with system partners and commissioners to submit a plan by the end of April 2018.
- The trust's corporate risk register did not accurately or fully reflect the serious risks to patient safety and quality arising from operational pressures due to insufficient capacity. The risk register provided to us, dated 1 February 2018, detailed three high scoring risks associated with patient flow as follows:
 - "Patient harm arising from poor flow across the trust and beyond" - this referred to the outlying of patients leading to mismanagement of patient care. This did not capture the knock on effect on patients' ability to access day care services due to departments being used as inpatient escalation areas.
 - "Patients harm arising from lack of timely discharge"
 - "Regulatory impact of breaching 4 hour access standard." This did not capture the serious risks to patient safety associated with crowding in the emergency department. Similarly, these risks were not fully captured or reported on in the trust's board assurance framework.
- The emergency department had not reviewed or audited safety systems to provide assurance that they were effective. In a frequently crowded emergency department, systems used to identify and prioritise the sickest patients and ensure regular patient monitoring are crucial. Performance data in respect of the time patients received initial assessment on arrival in the emergency department indicated that too many patients who arrived by ambulance were not promptly assessed. The streaming and triage arrangements in operation were not operating efficiently enough to facilitate prompt ambulance handover and assessment but they had not been reviewed or audited. The process for streaming and triaging self-presenting patients was undocumented (this was raised at our last inspection) and delays were not monitored so there was no assurance that this system was safe. The safety checklist, introduced in the emergency department in November 2017 had been audited only once since its introduction, despite the knowledge that staff compliance with this important safety system was poor. Following our inspection the trust advised us that monitoring of time to assessment had begun and regular auditing of safety checklists was taking place.
- The trust was unable to provide us with key data, which could be used to provide assurance of quality and safety and inform and drive improvements.
- The trust was unable to provide performance data in relation to the responsiveness of the psychiatric liaison service, despite the fact that this was raised as a concern at our last inspection and was identified as a factor affecting patient flow, in the trust's winter resilience plan.
- The trust was unable to provide data to show the number of times the ambulance cohorting protocol was activated, despite this being described as an internal critical incident. We were unable to obtain data in respect of the number of patients who were held on ambulances outside the emergency department because there were no available care spaces to accommodate them. The trust subsequently told us that they were working with the ambulance service to ensure that this information was available.
- Following our inspection the trust acknowledged that information systems were not as comprehensive or useful as they needed to be and that this function was to undergo urgent review with external support.