

# North West Anglia NHS Foundation Trust

## Peterborough City Hospital

### Inspection report

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### Ratings

#### Overall rating for this service

Inspected but not rated ●

Are services safe?

Inspected but not rated ●

Are services responsive to people's needs?

Inspected but not rated ●

Are services well-led?

Inspected but not rated ●

# Our findings

## Overall summary of services at Peterborough City Hospital

### Inspected but not rated



We carried out an unannounced focused inspection of the emergency department (ED) at Peterborough City Hospital following the 'Resilience 5 Plus' process. The 'Resilience 5 Plus' process is used to support focused inspections of urgent and emergency care services which may be under pressure due to winter demands or concerns in relation to patient flow and COVID-19.

We did not inspect any other services as this was a focused inspection in relation to urgent and emergency care. We did not enter any areas designated as high risk due to COVID-19. The inspection framework focused on five key lines of enquiry relating to critical care, infection prevention and control, patient flow, workforce and leadership and culture.

We previously inspected the ED at Peterborough City Hospital in July 2019 as part of our comprehensive inspection methodology. We rated it as requires improvement overall. Following that inspection, we issued one requirement notice and told the provider that they must take specific actions to ensure patient safety.

# Urgent and emergency services

**Inspected but not rated**



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

- We observed improvements in the physical environment where patients were rapidly assessed and treated (RAT). The new RAT process was introduced in August 2020, was now consultant-led between the hours of 10.00 to 20.00, with the ED consultant cover continuing for 16 hours out of every 24.
- There were clear clinical care pathways and protocols in place, with pre-agreed parameters for patients being seen in designated areas.
- Patients received timely clinical input and assessment. We observed patients' risk assessments were appropriately completed and that patients were reviewed based on their clinical needs.
- Staff were aware of, and used, the trust's escalation processes in order to manage flow and reduce risks of crowding within the department.
- There were systems in place for infection prevention and control. All staff and patients adhered to personal protective equipment (PPE) guidelines. There were clear isolation and separation areas to manage the care for patients due to COVID-19.
- Staff knew how to escalate deteriorating patients; Sepsis pathways were in place and we reviewed four patient records that showed those patients received appropriate care.
- Staff followed Royal College of Emergency Medicine (RCEM) standards and were not cohorting patients in corridors. The RAT area enabled staff to work with the local NHS ambulance trust to identify any patients likely to deteriorate whilst waiting to be seen and consultant cover enabled a clinician to review patients in a timely fashion.
- The paediatric urgent and emergency care area had been relocated as part of the trust's wider response to COVID-19. This was a spacious, visibly clean area that provided visual separation from the adult emergency and urgent care areas.
- During our inspection we observed mutually respectful interactions between staff and patients.

However:

- As patients were not being cohorted in corridors, at times of peak pressure, patients were being held on ambulances due to capacity issues within the wider hospital.

## How we carried out the inspection

We spoke with eight staff including the head of urgent and emergency care, , matron for urgent and emergency care, emergency department (ED) consultants, nurses, a patient tracker and the deputy chief nurse.

As part of the inspection we reviewed five patient care records and we analysed information about the service provided by the trust following our inspection.

You can find further information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

# Urgent and emergency services

## Is the service safe?

**Inspected but not rated**



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

### Environment and equipment

#### **The design, maintenance and use of facilities, premises kept people safe.**

The trust had implemented 'Red' and 'Green' areas within the ED to maintain patients and staff safety. Red areas were designated as high risk COVID-19 areas which enabled staff to provide care and support in line with the trust's COVID-19 risk assessments. Green areas were designated as safe areas for patients not suspected of having COVID-19 and staff followed PPE guidance. We observed staff adhering to the appropriate PPE requirements for both areas.

Patients arriving by ambulance initially have an infection control screening to ascertain if they have any signs or symptoms of Covid-19. If the patient is deemed as suspected or confirmed Covid-19, the patient is offloaded in 'Red' area dedicated for suspected Covid-19. The trust had improved the environment used for rapidly treating and assessing patients. The layout supported effective patient flow and improved privacy and dignity. The RAT had four designated bays, appropriately allocated staff and consultant oversight.

### Cleanliness, infection control and hygiene

#### **The service control infection risk well.**

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff routinely cleaned equipment, and patient trolleys, after every patient contact and labelled equipment to show when it was last cleaned. We observed staff using "I am Clean" stickers throughout the emergency department (ED) to show when equipment had been cleaned and was ready to use. Clear signage reminded staff, patients and any relatives of restricted access to high risk areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand washing facilities, alcohol gel and hand conditioner were readily available throughout the ED. The trust had dedicated areas for staff to put on and remove PPE and clear signage was in place to remind staff, patients and visitors of the importance of infection control. Staff followed, 'Bare below the Elbow' guidance, and wore PPE such as gloves and aprons whilst delivering care, in line with trust policy. The trust implemented PPE stations at every entrance to the ED for staff, patients and relatives to access face masks and other PPE essentials.

Monthly hand hygiene audit data provided by the trust following our inspection showed 100% staff compliance between April and November 2020.

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There were clear clinical care pathways and protocols in place, with pre-agreed parameters for patients being seen in designated areas. Patients arriving by ambulance used a dedicated ambulance entrance for both adults and children. All adult patients arriving by ambulance would go through the RAT area, unless identified as “Red”, query or COVID positive or resus. Children would either be taken into the children’s resus area or into the children’s ED. The ED team agreed a new pathway recently with the paediatric speciality team whereby all stable paediatric general practitioner (GP) referrals went directly to paediatric assessment unit.

## Assessing and responding to patient risk

### Staff completed risk assessments for each patient in a timely fashion.

Hospital ambulance liaison officers (HALO) employed by a local NHS ambulance trust worked alongside the ED team to support patient flow. This gave the opportunity to pre-alert staff if a patient required additional support and direct patient flow through the ED.

Staff identified and quickly acted upon patients at risk of deterioration. Staff knew about and dealt with any specific risk issues. This included the management of sepsis, neutropenic sepsis, stroke, falls and patient pressure care. Staff transferred any patient with frailty or pressure care needs from a trolley onto an appropriate pressure relieving mattress within four hours of arrival within the ED. Staff we spoke to knew how to recognise and respond to sepsis. The trust had a dedicated sepsis action plan in place.

Patients with concerns on neutropenic sepsis could call the acute oncology service for advice, who would then pre-alert the ED team to their arrival. The ambulance crews would call forward in cases of sepsis, suspected stroke or gynaecology patients. The HALO would assist in this process, ensuring that patients were greeted at the hospital and taken to the most appropriate area for treatment.

Patients received timely clinical input and assessment. During our inspection we observed patients being triaged routinely within 15 minutes of arrival by ambulance and streamed to the appropriate area within the ED. The nurse in charge checked triage and patient waiting times as part of their two hourly safety checks to escalate any patients of concern. Staff could monitor waiting times directly from the electronic patient record and escalate patients who were waiting too long to be seen.

Staff completed risk assessments for each patient swiftly and updated these assessments appropriately as patient care was delivered. Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly. We reviewed the records of five patients and found the patient safety check list completed for all patients. Staff followed the sepsis six bundle and escalated patients appropriately in the records we reviewed.

All staff we spoke with knew how to recognise and respond to the deteriorating patient and staff told us they had received training in how to escalate the deteriorating patient. Staff used a nationally recognised tool to identify deteriorating patients. The trust used the national early warning score system (NEWS2) for adults and paediatric early warning scores (PEWS) for children. An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs of respiratory rate, oxygen saturation, temperature, blood pressure, pulse and heart rate.

On main ED reception there was a designated member of staff streaming patients between 8am and 12pm seven days a week. This person was either a skilled registered nurse, emergency nurse practitioner or advanced care practitioner.

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After 12pm, the triage staff from within minors would be situated in the streaming area. Staff streamed patients to the minors area or back to the adult majors or resus if they had significant concerns. This meant there was a designated member of staff that had physical oversight of patients within the waiting areas and had oversight of any patients should they deteriorate.

## Staffing

### **The service had enough staff with the right qualifications, skills, training, and experience.**

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Staffing levels were displayed, as well as the name of the nurse in charge and emergency physician in charge (EPIC). We noted that nurse staffing levels at the time of our inspection were three below expected due to sickness, but managers had taken appropriate action based on patient acuity. The nurse in charge explained how they planned four weeks in advance for all shifts to ensure they had the right staff with the right competencies and skills to manage the ED safely.

In November 2020, the trust executive board approved an investment appraisal for Peterborough City Hospital (PCH) ED which aimed to recruit over 50 nursing positions within the ED to reduce the use of agency and bank staff. The leadership team recruited a senior band seven paediatric lead on both of its sites, band five and six registered children's nurses, nursery nurses and play specialists. Recruitment for additional paediatric staff was ongoing at the time of our inspection.

In the 12 months prior to our inspection, the nursing staff turnover was 12.57% and medical staff was 4.65%. Ten of those staff were registered nurses, eight of which left due to relocation, one progressed to complete their medical training and one resigned to care for a relative. The ED team had successfully recruited into 16 WTE posts, however there had been 15 staff leavers during the same period. All leavers were offered exit interviews and of the leavers six remained on flexible contracts. In July 2020, the ED increased its ED consultant establishment from 12 whole time equivalents (WTE) to 14 WTE to incorporate the consultant led RAT service.

The service had experienced periods of high sickness levels since the beginning of the pandemic and had measures in place to deal with this alongside unexpected surge in demand. The ED had a dedicated escalation policy for managing acute sickness as well as absences related to COVID-19.

In early March 2020, the ED saw a spike in acute staff sickness at almost 15% within ED. This was due to staff shielding and acute sickness. This rate dropped over the following six months to 5%. The ED lead nurse and human resources team worked closely to provide ongoing support from occupational health as well as the acute psychiatric team based in the ED. The ED experienced another increase in COVID related sickness absence in December 2020, rising to 12%, due to staff and/or their family members displaying COVID symptoms or testing positive for COVID and shielding requirements.

There were not always two qualified children's nurses on duty in the paediatric ED at all times. However, the ED team had risk assessments in place and mitigated this by ensuring that if there was only one children's nurse on duty, they were supported by an adult trained nurse that had completed their paediatric competencies. The ED team also used long line agency nurses with paediatric competencies or who were registered children's nurses to support the team. The ED lead consultant had completed additional paediatric training to provide support and the children's ED was located

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next to the children's ward so access to paediatric consultant on call 24 hrs. The ED were utilising 31 whole time equivalent (WTE) agency / bank staff monthly due to the expanded footprint within the department, including the RAT areas and the dedicated red area and green areas to manage Covid-19. The trust offered bank staff incentive schemes that ran on a six-month rolling basis, reviewed by the ED leadership team, chief nurse, finance and director of workforce.

Medical staffing met with Royal College of Emergency Medicine (RCEM) recommendations of 16 hours of consultant presence per day. Staff we spoke with during the inspection told us that the consultant team often worked over their allotted hours to provide ongoing support to the patients and staff. Medical staff covered seven days a week with the remaining eight hours on-call.

## Is the service responsive?

Inspected but not rated



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

### Access and flow

**People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.**

During November and December 2020 hospital bed capacity was routinely above 90% often reaching 97% which impacted on the emergency departments (ED) ability to transfer patients into the ward areas. Ward areas had been significantly reconfigured to provide care and treatment of patients with COVID-19. Staff told us delays in COVID-19 testing affected patient discharge to external care providers, reducing capacity further.

Royal College of Emergency Medicine (RCEM) triage standard states that triage should be a face-to-face encounter that should occur within 15 minutes of arrival or registration and should normally require less than 5 minutes contact. In September, October and November 2020, the median time from arrival to initial assessment (emergency ambulance cases only) was eight minutes, however the average time from arrival to initial assessment was 27 minutes, 24 minutes and 31 minutes respectively (September to November 2020).

Data supplied by the trust following our inspection showed that in September 2020, the median time to triage for an adult patient was 14 minutes. This improved during October and November 2020, where the median time to triage was 11 minutes.

Paediatric triage times during the same period were 22 minutes in September 2020, 17 minutes in October 2020 and 15 minutes in November 2020.

In September 2020, data supplied by the trust following our inspection showed that 5.3% of ambulances remained at hospital for more than 60 minutes; this increased to 8% in October and again further in November to 8.5%. Staff followed Royal College of Emergency Medicine (RCEM) standards and were not cohorting patients in corridors. Staff told us there had been significant delays in ambulance turnaround times as patients were being held on ambulances due to capacity issues within the ED and the wider hospital.

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Data supplied by the trust following our inspection showed that during September 2020, 1.9% of adult patients spent over 12 hours within ED, this increased to 3.8% in October and 4.4% in November. The ED team had appropriate systems to escalate patients who had been waiting extended periods within the ED, including clinical reviews, discussion at staff safety huddles and handovers as well as tracking patients on the hospital's electronic patient record system. Managers we spoke with told us that delays were often due to capacity across the hospital and delays whilst patients waited for COVID-19 tests results in order to be admitted, transferred or discharged from the department.

In September 2020, 2.7% of patients waited 4 to 12 hours from decision to admit. This increased to 5% in October and 5.6% in November 2020.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. Data supplied by the trust following our inspection showed that the ED failed to achieve this target for the three months prior to our inspection. In September 2020, 68.6% of patients were admitted, transferred or discharged within four hours of arrival in the ED. This percentage remained similar in October with 68.2% but worsened to 59.4% in November 2020. Managers we spoke to explained this was due to reduced space to accommodate red and green areas and wider capacity within the hospital due to the impact of the increased number of patients attending and being admitted with COVID-19.

The service was following national guidance on the care and treatment of patients in emergency settings and was not queuing or cohorting patients in corridors. We observed no overcrowding during our inspection.

The RAT area enabled staff to work with the local NHS ambulance trust to identify any patients likely to deteriorate while waiting to be seen and consultant cover enabled a clinician to review patients in a timely fashion.

The trust had reviewed its ambulatory care service and elective clinics to ensure they had capacity to see same day emergency patients. At the time of our inspection, the urgent care footprint and other supporting services were undergoing refurbishment to offer further same day emergency care (SDEC) services. The trust had plans for further work to increase SDEC activity and introduce a new surgical admissions unit (SAU) adjacent to its main ED to be completed in March 2021. The trust planned to transfer surgical pathways from the existing ambulatory care unit (ACU) to the SAU, creating more capacity on the ACU for the medical assessments of ambulatory patients. Other schemes and pathways, for example an acute frailty pathway, were also being developed to support flow through the ED.

There were clear and effective arrangements for transfer to other services. The service worked with others in the wider system and local organisations to plan care. The trust was participating in a national 'Navigation Project' to reduce congestion in the ED waiting room. The trust told us this enabled them to appropriately redirect 20-30% of walk-in attendances to alternative appropriate care facilities, not just internally within the trust but also to other services located in the community for example the city centre care or the patients' own general practitioner (GP). Following our inspection, the trust informed us that the pilot was most successful at its start when on average they navigated around 14% of walk-in adult patients per month away from the ED, on some days up to 23%. As the COVID pandemic progressed and staff sickness increased, the ability to cover the ED navigation process reduced as direct nursing care was prioritised to ensure safety in the department. As part of the trust's ongoing development and relocation of its urgent treatment centre by the end of June 2021, they were looking to continue the navigation processes and how this could be best delivered.

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There were systems in place to manage the flow of patients through the (ED) and identify any patient waiting extended periods to be seen. The trust had an incident control room where the trust's accountable emergency officer had oversight of organisational position including site status, risks and issues regarding flow. Staff could appropriately escalate any safety or flow issues in line with the trust's capacity management and escalation policy.

The senior leadership team (executives and divisional leadership teams) had oversight and involvement in flow issues on a day to day basis through the daily operational senior leadership huddles. These were chaired by the chief operating officer and had trust divisional director representation to discuss issues relating to flow, emerging risks and issues and plans for the next 24 to 48-hour period. The daily director on call engaged with the ED team to support flow and escalate any performance issues.

There were processes in place to monitor waiting times and managers and staff worked to make sure patients did not stay longer than they needed to. Processes for monitoring waiting times were embedded in the day-to-day quality processes; staff discussed waiting times during safety huddles and the nurse in charge escalated any concerns regarding patients who were approaching a breach in waiting or triage times during their two hourly safety checks. During September 2020, 2.7% of patients left without being seen, this reduced to 2.2% in October and 2.1% in November 2020.

## Is the service well-led?

**Inspected but not rated**



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

### **There was a stable leadership team in place and leaders had the skills and abilities to run the service.**

Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the services for patients and staff.

The trust had restructured the ED management team across both Peterborough City hospital (PCH) and Hinchingsbrooke hospital (HH) sites and had no leadership vacancies at the time of our inspection. The leadership team included ED consultant leads on both sites, a head of urgent and emergency care across both sites and a dedicated service manager at PCH. The matron for urgent and emergency care worked with the ED lead nurse across both sites to ensure consistency of services.

Managers we spoke with told us there had been a positive impact on leadership during the COVID-19 pandemic as the team pulled together throughout the first wave and embraced different ways of working. Welfare and support services were actively promoted throughout the staff team, including the use of 'wobble' rooms where staff who felt unsure or needed reassurance could spend time to gather their thoughts and seek support. Occupational health and additional supervision to support staff to cope with the challenges they faced were also available.

### **Culture**

**Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care.**

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Staff we spoke with described an open culture where learning from incidents was encouraged and staff were actively engaged in developments within the department.

Staff felt valued, they felt that the leadership team had provided additional support during the pandemic and that a culture of working together had been a key focus to ensure patient and staff safety.

During our inspection we observed mutually respectful interactions between staff and patients.

## Governance

**Leaders operated governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

Escalation plans had been brought into effect during the pandemic. The trust used a multi-disciplinary approach to managing key challenges within the ED. This included the management of flow using combined operational and clinical meetings with divisional teams to address key issues, for example, staffing levels, escalation and risk.

The trust was engaged with the emergency care intensive support team (ECIST), among others, to support the team to make sustainable performance improvements in the ED. Staff we spoke with told us that leaders across the organisation engaged in improvement and escalation activities, for example, the chief executive officer led forums with clinical teams to discuss challenges and potential opportunities for performance improvement.

Managers we spoke with told us the trust's senior leadership team understood the challenges in relation to the quality and sustainability of effective patient care during the COVID-19 pandemic. The executive team had regular oversight of the trust's unplanned care improvement plan and actively supported and challenged progress.

Leaders and teams used systems to manage performance effectively. The trust told us that the urgent care governance structure was revised in April/May 2020 by the head of urgent care. The joint monthly clinical business unit meeting which covered all urgent care areas was removed and replaced with a series of meetings with distinct focus and purpose. These include a monthly ED clinical governance meeting, covering the ED, medical assessment unit (MAU) and clinical observation decision unit (CODU), an ED operational performance group meeting, an ambulance handover focus group meeting and a children and young people's services steering group.

Staff identified and escalated relevant risks and issues, identified actions to reduce their impact and had plans to cope with unexpected events. The ED leadership team held monthly ED risk register review meetings with matron for urgent and emergency care, lead nurses and service managers. These meetings were chaired by the head of urgent care and fed into the formal ED clinical governance meeting. We reviewed the ED risk register and found this was up to date and reflected the existing risks within the ED. These included patients waiting for more than 12 hours on trolleys, overcrowding in the ED, offloading times for ambulances, managing social distancing, and maintaining safe staffing levels. The trust had action plans and mitigation in place, for example, social distancing guidance, ED risk assessments and dedicated risk and safety escalation plans to manage capacity and flow.

There were regular monthly meetings in place to ensure resilient leadership and encourage a positive and caring culture within the team that had safety and patient care as the focus. These included monthly shift coordinators meetings with

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the ED lead nurse supported by the management team and trust human resources team. Monthly consultants and shift coordinators meeting aimed to improve the relationships and communications of the urgent care environment to improve patient experiences and a monthly consultants meeting chaired by the ED clinical lead. These meetings enabled staff to discuss safety, performance and risk issues.

The ED held monthly open forums to enable the ED leadership team to update staff on key developments in ED and wider urgent care areas. This gave staff group representatives opportunities to feedback on areas for improvement and discuss any particular challenges that needed addressing, for example any risks or concerns. The trust used IT platforms to support wider attendances from the staff team, enabled social distancing and offered flexibility for staff to join meetings and discuss risk.

## Management of risk, issues and performance

**Leaders and teams used systems to manage risk however performance issues remained that impacted on the quality and safety of care.**

The ED held bi-weekly urgent care leadership meetings to discuss key areas of performance and safety; these were attended by a multidisciplinary team including the clinical leads for ED and acute medicine, head of urgent care and service manager.

In September 2020, the ED team implemented bi-weekly paediatric leadership meetings to improve staff relations, increase focus on paediatrics and bring integration between the paediatric services and ED across site.

The trust had paediatric task and finish groups cross-site utilising the newly created band seven paediatric nurse post at Hinchingbrooke Hospital ED. The ED paediatric consultants chaired the groups, supported by a wide group of staff from various areas, to reflect the standards within the Royal College of Emergency Medicine (RCEM). The group was implemented to address any compliance gaps against the paediatric national standards and make any required improvements.

Bi-weekly urgent care business meetings reviewed investment appraisals, cost improvements schemes, capital investments and demand and capacity reviews.

Staff told us the chief executive officer was prominent in the service, often calling in to see patients and staff. Staff we spoke with said that local managers listened to concerns and were always willing to provide support and guidance.

In December 2020, the ED leadership team launched a new weekly ED leadership newsletter capturing key messages for the staff team and feedback from various events, performance and safety.

# Our inspection team

The team that inspected the service comprised of a CQC lead inspector, and specialist advisor. The inspection team was overseen by Mark Heath, Interim Head of Hospital Inspection.