Worcestershire Royal Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at Worcestershire Royal Hospital on 16 December 2019, in response to concerning information we had received about the care of patients in this department. At the time of our inspection the department was under adverse pressure.We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology.We found that:

Ambulance handover delays remained a challenge, with some patients experiencing delays of more than 3 hours from arrival by ambulance to being handed over to trust staff for commencement of care and treatment. Whilst the trust had procedures in place for assessing patients who experienced delays of 60 minutes or more from arrival to handover, staff were not consistently following these procedures; further, the trust had a lack of robust assurance and oversight for ensuring such procedures were consistently followed. National standards require trusts to ensure that 95% of patients arriving by ambulance are clinically assessed within 15 minutes of arrival. The trust had not met this target in any month between January 2019 and December 2019. The trust could not demonstrate any sustained improvement in this metric.

The trust monitored patients who arrived by ambulance who did not receive a clinical assessment within 15 minutes but had received a clinical assessment within 60 minutes. This metric also demonstrated consistent poor performance without any marked improvement between January 2019 and December 2019.

As a result of this inspection, and due to the level of concern we had, CQC opted to use their urgent enforcement powers to ensure the provider took swift action to protect service users from harm. We imposed a range of conditions on the provider's registration including, but not limited to requiring the trust to ensure that all patients who arrived by ambulance were clinically assessed within 15 minutes, in order the trust could determine the sickest patients or those patients who required time critical care or treatment.

Patient's continued to be nursed along the corridor for extended periods of time. The total number of hours patient's spent on the corridor was reported as 9,530 hours in January 2019 and 7,952 hours in December 2019. A review of data for each month in 2019 suggested limited overall improvement, suggesting staff had normalised the use of the corridor. as compared to the use of the corridor only being reserved for times of significant surge.

The trust had recognised an increase in the number of patients who sustained pressure damage whilst waiting in the emergency department (specifically, there had been an increase in grade two pressure ulcers being attributed to the emergency department). The trust had taken action to deploy a tissue viability nurse to support ED nursing staff, as well as ensuring there was sufficient pressure relieving devices for staff to use. However, patients remained on trolleys for extended periods of time due to a lack of space in the department for patients to be transferred on to a more appropriate hospital bed. We therefore imposed a second condition on the provider's registration requiring them to ensure staff undertook dynamic risk assessments of all patients in the ED to ensure patients were managed in the most appropriate clinical area.

Patient's referred to medical and surgical specialties could expect to wait extended periods of time before being reviewed. Staff were not effectively using the trust escalation protocol. There had been some marginal improvement in the average time to specialty review between February 2019 (104 minutes (compared to 146 minutes in January 2019) and July 2019 (109 minutes). However, performance started to deteriorate thereafter, increasing to 130 minutes in December 2019. We therefore imposed a third condition on the provider's registration which required them to ensure they operated an effective professional standards protocol so patients received a timely review by specialty teams.

Summary of findings

There was a general poor understanding and use of the national operational pressures escalation levels (OPEL) protocol issued by NHS Improvement and NHS England. Front-line staff assumed they were at the highest level of escalation (OPEL 4) on the day of the inspection however the trust executive team reported the trust was at OPEL 2. This was despite there being 18 patients being nursed on the corridor, three or more ambulances experiencing delays of one hour or more in handing over their patients, and 19 patients waiting for an inpatient bed to become available.

There were insufficient numbers of nursing staff deployed to support the children's area of the emergency department, in line with national recommendations. During the inspection, six children and their carer/parents were left in the department with only a student nurse present for a period of at least ten minutes. The trust executive team considered this not to be a risk and referred CQC to the trust standard operating procedure which required parents or carers to contact a member of staff should they be concerned about their child. We considered this to be inappropriate in that parents/carers may not be sufficiently trained to recognise an infant, child or young person whose clinical condition was deteriorating. The trust subsequently amended the standard operating procedure for the children's area of the emergency department and provided assurances that two members of staff were rostered at all times to support the area.

As a result of this inspection, we have identified areas which the trust make take to ensure they comply with relevant elements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 fundamental standards.

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

Importantly, the trust must:

- The trust must ensure that ambulance handovers are timely and effective.
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments.
- The trust must ensure that patients receive medical and specialty reviews in a timely manner.
- The trust must ensure that consultant and nurse cover in the department meets national guidelines. Trainee consultants must not be classed as ‘consultants’ on the staffing rota.
- Fully implement the trust wide actions to reduce overcrowding in the department.
- The trust must ensure that the privacy and dignity of patients receiving care and treatment in the emergency department is maintained at all times.

Following this inspection, we have taken urgent enforcement action, to impose conditions on the trust's registration to make urgent improvements in the quality and safety of care for patients.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	**Inadequate** 	We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection, the department was under adverse pressure with significant overcrowding. Whilst staff did their best to care for patients with compassion, we found some patients had delays to initial assessments and timely treatments. The trust was implementing a range of actions to reduce overcrowding. We did not inspect any other core service or wards at this hospital. We did not cover all key lines of enquiry. We have rated the service as inadequate overall.

Summary of findings

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Background to Worcestershire Royal Hospital

Worcestershire Royal Hospital is a type one emergency department based on the outskirts of Worcester city. The hospital is a designated major trauma unit; this means patients sustaining major trauma injuries through road traffic incidents or other similar modes of injury can be stabilised, and in some cases treated at Worcestershire Royal Hospital, or alternatively, transferred to a major trauma centre.

The department includes:

- Two triage rooms.
- Four resuscitation rooms.
- Four high care rooms.
- Twelve majors rooms.
- Three paediatric cubicles & separate paediatric waiting area plus minors area with four exam rooms (an isolation facility, treatment room, plaster room and ophthalmology room), and also two GP rooms.
- Ambulatory emergency care unit with two clinic rooms operating seven days a week.
- A 25 bedded medical short stay unit which encompasses a four bedded medical high care unit.

Worcestershire Acute Hospitals NHS Trust was established in April 2000 and provides acute healthcare services to a population of around 580,000 in Worcestershire and the surrounding counties.

Trust activity for the emergency department from August 2017 to July 2018:

- 71,413 A&E attendances.
- 14,235 Children attendances.
- 48,985 ambulance attendances.
- 4.31% patients left without being seen.
- 6.31% re-attendances within 7 days.

Trust activity for the preceding 6-weeks to 4 December 2019 was reported as follows:

- 60-63% of patients are admitted, transferred or discharged within four hours. This is significantly worse than the England average.
- 34% of patients were seen by a clinician within 60 minutes.
- On average, 15 ambulances a day experienced delays of 60 minutes or more from arrival to handing over their patient to trust staff.
- The number of emergency admissions (referred to as the conversion rate which relates to the number of patients who present to an emergency department and who are subsequently admitted for ongoing care and treatment) ranged between 28 and 30%.
- The trust reports an overall increase(year to date to 30 December 2019) in patient activity of 5.8% when compared to the previous year.
- The trust reports an overall increase in ambulance conveyances, year to date to 30 December 2019 of 5.9% when compared to the previous year.
- The number of emergency admissions had also increased by 6.6% year to date to 30 December 2019 when compared to the previous year.

(Source: Trust correspondence dated 31 December 2019)

Inspection and regulatory history

November 2016

We carried out an announced inspection of the emergency department in November 2016. Following that inspection, we rated urgent and emergency care services as inadequate.

April 2017

We inspected the emergency department in April 2017 and subsequently took regulatory action to ensure the trust made significant improvements against a range of areas.

November 2017

We inspected the emergency department in November 2017 and rated it inadequate overall. This was a focused inspection.

March 2018

We inspected the emergency department in March 2018 as a planned inspection and rated the safe and caring key

Summary of this inspection

questions as requires improvement. The service was rated inadequate overall due to the responsive and well-led key questions having previously been rated inadequate.

January 2019

A focused inspection was carried out in January 2019 as part of the Care Quality Commission winter pressure resilience inspection programme. At that inspection we found similar issues to those previously identified. Patient flow remained a significant challenge, delays in ambulance handovers, lack of clinical space for medical and nursing staff to assess and treat patients in a timely fashion and persistent department overcrowding.

May 2019

We inspected the emergency department (ED) at Worcestershire Royal Hospital in May 2019 as a planned inspection. We rated it as requires improvement overall. Whilst there had been improvements in a range of areas, patient flow remained a significant challenge, resulting in patients experiencing delays in being handed over from ambulance crews, as well as patients being cared for extended periods of time in non-clinical areas such as the main corridor of the department. There remained little compliance with the trust professional standards protocol which required specialty doctors to review patients within 30 minutes of being referred.

December 2019

As a result of this most recent inspection of Worcestershire Royal Hospital which took place on 16 December 2019, the Care Quality Commission took urgent action and imposed conditions on the provider's registration. Those conditions are referenced at the end of this report, however in summary, we found:

Ambulance handover delays remained to be a continuing challenge, with some patients experiencing delays of more than 3 hours from arrival by ambulance to being handed over to trust staff for commencement of care and treatment. Whilst the trust had procedures in place for assessing patients who experienced delays of 60 minutes of more from arrival to handover, staff were not consistently following these procedures; further, the trust had a lack of robust assurance and oversight for ensuring such procedures were consistently followed. National standards require trusts to ensure that 95% of patients arriving by ambulance are clinically assessed within 15 minutes of arrival. The trust had not met this target in any month between January 2019 and December 2019. The trust could not demonstrate any sustained improvement in this metric.

The trust monitored patients who arrived by ambulance who did not receive a clinical assessment within 15 minutes but had received a clinical assessment within 60 minutes. This metric also demonstrated consistent poor performance between January 2019 and December 2019.

Patient's continued to be nursed along the corridor for extended periods of time. The total number of hours patient's spent on the corridor was reported as 9,530 hours in January 2019 and 7,952 hours in December 2019. A review of data for each month in 2019 suggested limited overall improvement, suggesting staff had normalised the use of the corridor. as compared to the use of the corridor only being reserved for times of significant surge.

The trust had recognised an increase in the number of patients who sustained pressure damage whilst waiting in the emergency department (specifically, there had been an increase in grade two pressure ulcers being attributed to the emergency department). The trust had taken action to deploy a tissue viability nurse to support ED nursing staff, as well as ensuring there was sufficient pressure relieving devices for staff to use. However, patients remained on trolleys for extended periods of time due to a lack of space in the department for patients to be transferred on to a more appropriate hospital bed.

Patient's referred to medical and surgical specialties could expect to wait extended periods of time before being reviewed. Staff were not effectively using the trust escalation protocol. There had been some marginal improvement in the average time to specialty review between February 2019 (104 minutes (compared to 146 minutes in January 2019) and July 2019 (109 minutes). However, performance started to deteriorate thereafter, increasing to 130 minutes in December 2019.

There was a general poor understanding and use of the national operational pressures escalation levels (OPEL) protocol issued by NHS Improvement and NHS England. Front-line staff assumed they were at the highest level of escalation(OPEL 4) on the day of the inspection however the trust executive team reported the trust was at OPEL 2. This was despite there being 18 patients being nursed on

Summary of this inspection

the corridor, three or more ambulances experiencing delays of one hour or more in handover their patients, and 19 patients waiting for an inpatient bed to become available.

In order to reduce duplication and as means of providing further context, the following capacity reports were noted during the inspection on 16 December 2019:

12:30

15 ambulances present outside Worcestershire Royal Hospital.

Three patients remained on board ambulances due to a lack of capacity in the department.

Four ambulances had been waiting more than thirty minutes to hand their patients over.

71 patients were in the department with a trolley occupancy of 262%.

20 patients had decision to admit and were awaiting beds. The longest wait in the department was 20 hours and 24 minutes.

There was a wait of three hours and 46 minutes for triage.

The time to be seen by a clinician in the ED on the majors pathway was two hours and 32 minutes.

Time to be seen by a clinician in the ED on the paediatric pathway was three hours and 16 minutes.

Four patients were in the resuscitation room, resulting in the area operating at full capacity.

Eight patients had been in the ED for more than eight hours.

12 specialty patients had been waiting more than 30 minutes for a review.

Summary of this inspection

16:15
Average handover time for Priority A patients was reported as 27 minutes 34 seconds.

Average handover time for Priority B patients was reported as 39 minutes 50 seconds.

Average handover time for Priority C patients was reported as 1 hour and 14 minutes.

72 patients were in the department with a trolley occupancy of 224%.

19 patients had decision to admit and were awaiting beds. The longest wait in the department was 23 hours hours and 24 minutes.

There was a wait of one hour and 3 minutes for triage.

The time to be seen by a clinician in the ED on the majors pathway was two hours and 50 minutes.

Time to be seen by a clinician in the ED on the paediatric pathway was one hour and 37 minutes.

Four patients remained in the resuscitation room.

Ten specialty patients had been waiting more than 30 minutes for a review

Our inspection team

Our inspection team included a CQC inspector and two specialist advisors consisting of an emergency care consultant and the national professional advisor for urgent and emergency care.

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

How we carried out this inspection

This was a focused unannounced inspection of the emergency department at Worcestershire Royal Hospital on 16 December 2019.

We did not inspect the whole core service therefore we have not reported against, or rated the effective key question. We did not inspect any other core service or wards at this hospital, however, we inspected the emergency department at the Alexandra hospital using the same inspection methodology on the same day.

During this inspection, we inspected using our focused inspection methodology. We did not cover all key lines of enquiry. However, because we took enforcement action, we opted to rate the safe, responsive and well-led key questions as detailed in the summary section of this report.

Inadequate

Urgent and emergency services

Safe	Inadequate
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate

Information about the service

Worcestershire Royal Hospital is a type one emergency department based on the outskirts of Worcester city. The hospital is a designated major trauma unit; this means patients sustaining major trauma injuries through road traffic incidents or other similar modes of injury can be stabilised, and in some cases treated at Worcestershire Royal Hospital, or alternatively, transferred to a major trauma centre.

The department includes:

- Two triage rooms.
- Four resuscitation rooms.
- Four high care rooms.
- Twelve majors rooms.
- Three paediatric cubicles & separate paediatric waiting area plus minors area with four exam rooms (an isolation facility, treatment room, plaster room and ophthalmology room), and also two GP rooms.
- Ambulatory emergency care unit with two clinic rooms operating seven days a week.
- A 25 bedded medical short stay unit which encompasses a four bedded medical high care unit.

Summary of findings

We did not inspect the whole core service as this was a focused inspection.

There were delays in off-loading ambulances and resultant delays in assessment and treatment for some patients due to overcrowding and poor overall grip and control of patient activity and flow across the organisation.

Whilst the service mostly had suitable premises, there were insufficient cubicles to accommodate all the patients in the department when it was overcrowded. Patients were being cared for in a crowded corridor at the time of the inspection.

Triage times were not always in line with guidance. Some patients waited considerable time to be assessed due to overcrowding.

Whilst risks to patients were assessed and their safety monitored and managed, not all patients received treatment in a timely manner due to overcrowding.

There were not always enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care at the time of the inspection,. Consultant cover in the department did not meet recommended guidelines. Some doctors told us they needed more doctors in order to keep the department safe when it was overcrowded.

Patient privacy and dignity was not always protected due to overcrowding. Patients needs were not always considered in a holistic way.

Inadequate

Urgent and emergency services

Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.

Specialty doctors did not respond to patients in a timely manner when referred by the ED team. Whilst there had been system wide agreement for ED doctors to make decisions to admit patients, ED doctors were not making such decisions, resulting in patients spending more time in the ED than was necessary whilst awaiting clinical review by relevant medical specialty teams.

There were not always enough nursing staff deployed to ensure the children's emergency department was staffed at all times, in line with national recommendations.

There remained little improvement in the overall quality and effectiveness of the service, despite there having been concerns raised by CQC and other organisations since 2015. New improvement plans had been developed which mirrored previous improvement plans, and so it was not possible to determine how a new plan would drive change. We were concerned there remained a lack of capacity and capability not only in the trust, but also across the wider health system to address the continued failings of the urgent and emergency care pathway at Worcestershire Royal Hospital. A new system oversight board had been created to provide additional scrutiny to the Worcestershire home first improvement project. However, terms of reference for the board remained in draft format, a lead director had not been appointed to deliver the programme, nor had the role for such a post been advertised despite it having been approved by the health system.

Governance processes were not sufficiently developed to ensure the quality and safety of the service was given the highest priority within the organisation. The executive team were not sufficiently sighted on the challenges faced by the emergency care team. Staff reported poor visibility of the executive team despite their offices being within close proximity to the ED. There remained a lack of robust challenge and accountability from the executive team and the board for ensuring specialty teams complied with the trust professional standards protocol.

Are urgent and emergency services safe?

Inadequate

Environment and equipment

Whilst the service mostly had suitable premises, there was insufficient space to accommodate all the patients in the department at the time of the inspection. The department was overcrowded with many patients being cared for in corridors. There were significant delays in off-loading ambulances and resultant delays in assessment and treatment for some patients.

We had previously reported the design and layout of the emergency department was no longer suitable to meet the growing demands of the service. The department was operating at 262% capacity at the time of the inspection, with a total of 71 patients present. The reasons for such high occupancy was noted to be multi-factorial and is discussed throughout this report due to the nature of how we assess individual key lines of enquiry.

On our arrival, we observed 15 ambulances parked outside Worcestershire Royal Hospital. At 12.30 we reviewed the emergency department activity board which showed that four patients conveyed by ambulance had been waiting for more than thirty minutes to be handed over to trust staff; three patients remained on ambulances because there was no space to receive patients in to the designated senior initial assessment nurse (SIAN) area. It was noted the longest handover delay on 16 December was reported as 3 hours and 44 minutes.

18 patients were noted to be on trolleys along the main corridor and along two sub-corridors. Those located in the furthest corridor were not visible unless a member of staff was physically present in that area. Three patients were present in that area. Whilst not seen by the inspection team, the trust report patients in this area had access to call bells which were installed in 2017. The lack of clinical line of sight meant there was a risk patients who may deteriorate may not have been immediately identified and therefore leading to a delay in time-critical treatment.

Inadequate

Urgent and emergency services

Due to a lack of capacity and appropriate clinical space, patients could not always receive care and treatment in an appropriate setting.

During the inspection on 16 December 2019, we noted one patient arrived by ambulance with symptoms of indigestion. The local ambulance trust had ruled out a possible ST elevation myocardial infarction (STEMI; a form of heart attack) by way of a three lead ECG. Due to capacity challenges, the ambulance crew experienced a delay of 23 minutes before handing the patient over at which time the nurse was sufficiently concerned by the clinical presentation that they carried out a 12 lead ECG (a more detailed analysis of the heart rhythm) which confirmed the patient was suffering from a STEMI. The patient was reviewed by an ED consultant and referred to the cardiac catheter service for intervention. Approximately two hours after their arrival, the patient remained in the corridor attached to a defibrillator due to a lack of capacity in the resuscitation room.

Prior to the inspection we reviewed all clinical incidents relating to urgent and emergency care services at Worcestershire Royal hospital for the period of 1 June 2019 to 1 December 2019. We noted a number of incidents related to staff from other departments reporting patients being admitted to wards from the emergency department (ED) with grade two pressure ulcers which had not previously been recognised, therefore potentially meaning the damage was caused whilst patients were in the ED. We noted that all patients on the corridor were being nursed on trolleys. We discussed the increase in department acquired grade two pressure ulcers with staff. They reported that due to a lack of space in the corridor, it was necessary to care for patients on trolleys. Staff described action being taken to address the issue, including in-reach support from tissue viability nurses, and an increase in the availability of pressure relieving equipment. However, staff reported, and we observed frail elderly patients remaining on trolleys for extended periods of time, therefore pre-disposing those individuals to the risk of harm due to not being nursed on an appropriate bed.

Due to the cold weather, staff had opted to not locate patients directly in between two sets of automatic doors, used for patients arriving by ambulance. Instead, the local leadership team had opted to use a area in a sub-corridor. We noted patients present in this area for the duration of the inspection. A set of fire doors to this area had been propped open despite signs on the doors stating they were in fact fire doors and should not be "Wedged open". We raised this with the trust in our initial written feedback to prompt them to take remedial action to ensure patients and staff were kept safe and that appropriate risk assessments were completed should the use of the area continue, thus requiring fire doors to be blocked. The trust reported a risk assessment had been completed, The trust reported "We have recognised the risks within the Department with regards to the Fire exit door left open. The risk has been assessed using a Department environmental risk assessment. We have worked closely with our Fire Officer who undertakes a weekly review and provides an action plan which the team review on an ongoing basis dependent on the placement of patients in the ITU corridor."

We checked a range of specialist equipment, including adult and children's resuscitation equipment. Equipment was clean and organised, and a review of equipment checklists showed that daily checks had routinely completed. Clinical waste was segregated and stored appropriately.

Assessing and responding to patient risk

Triage times were not always in line with guidance. Some patients continued to wait considerable time before being assessed.

The department had a triage system which was aligned to a nationally recognised triage system. This categorised patients according to a risk rating of one to five. For example, level two was a threat to life which required immediate nurse assessment and to see a doctor within 15 minutes; and level four was a moderate risk, to see a nurse within one hour and a doctor within two hours.

Prior to the inspection, we were made aware of a serious incident in which a patient experienced a delay in being handed over to trust staff, and who subsequently rapidly deteriorated and died shortly after being transferred in to the emergency department. At the time of writing this report, the investigation remained on-going, however following the inspection, we were made aware of a second incident in which a patient deteriorated whilst being held on an ambulance for an extended period of time, and who required resuscitation. Again, whilst the

incident remained under investigation, it was noted the patient had been on an ambulance for 60 minutes before having received a clinical assessment by trust staff as part of the trust's global risk assessment tool (GRAT).

Standards set by the Royal College of Emergency Medicine states initial clinical assessment should take place within 15 minutes of arrival. During December 2019, this was achieved for 68% of attendances by ambulance and 65% of patients who self-presented. The department failed to reach 95% compliance with this target in any month during 2019 for both ambulance attendances, and patients who self-presented. This meant there was a risk patients could potentially deteriorate in the emergency department waiting room or on an ambulance, or whilst in the ambulance waiting area, before they had been clinically assessed. Further, as has already been reported, during the inspection, we noted one patient who had been delayed by over 3 hours in being handed over to trust staff. Information reviewed by the inspection team identified that between 1 December and 17 December, 208 patients conveyed to Worcestershire Royal Hospital experienced delays in being handed over. Whilst staff were sighted on the challenges, there had been no significant improvement in resolving what had become a long-standing concern, and despite there having been clinical incidents related to patients being delayed in being clinically assessed in a timely way there was no robust long-term and measurable solution.

The trust reported that due to capacity demands and a lack of space in the department, a standard operating procedure had been developed which was invoked when patients could not be handed over in a timely way or in-line with national standards. The protocol stated that whilst patients would be registered on the trust's ED database, the clinical responsibility of the patient remained with the ambulance crew and the hospital ambulance liaison officer (HALO). This was contrary to guidance issued by NHS England and NHS Improvement in November 2017 ("Addressing ambulance handover delays: actions for local accident and emergency delivery boards") which mandated that "The patient is the responsibility of the ED from the moment the ambulance arrives outside the ED, regardless of the exact location of the ambulance". We asked the trust to confirm their position in regards to the clinical ownership of patients present at the ED but who remained on an ambulance, or with an ambulance crew inside the ED, however we were only provided with the ambulance handover SOP. Therefore, this suggested there remained ambiguity as to who was clinically responsible for such patients; this created a risk as there could be omissions in care should an ambulance crew adopt the national position that patients were the clinical responsibility of the trust from the moment they arrived at the ED.

On 18 December 2019, we asked the trust to provide the Care Quality Commission (CQC) with information setting out how the trust was assured all patients conveyed by ambulance were clinically assessed within the national standard of fifteen minutes. The trust provided CQC with the standard operating procedure detailing the responsibilities for both trust staff and ambulance staff. The trust also provided audit results for the implementation of the global risk assessment tool (GRAT)at the six hour mark. The trust did not submit any information which provided assurances that patients experiencing delays in handover were being clinically assessed by trust staff within 15 minutes. We also considered the performance against the six hour GRAT to be varied when reviewing the audit results for 6 October 2019 to 15 December 2019. This meant the trust could not be assured that patients received a timely assessment, especially where there were delays in patients being handed over. This presented a significant risk in that patients at risk of deterioration were unlikely to be identified early to allow for timely care and treatment.

The national early warning score (NEWS2) system and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: ‘acutely ill adults in hospital: recognising and responding to deterioration’ (2007). NEWS2 is a point system implemented to standardise the approach to detecting deterioration in patients’ clinical condition. We looked at 10 NEWS/PEWS charts and saw that they were completed correctly however there were some minor omissions including frequency with which observations being completed occasionally fell outside the local protocol.

We found that in one case, a patient deteriorated which was quickly recognised by the nurse caring for the patient. Contemporaneous notes were clear and concise and described the escalation the nurse took, which was in line with local policy. A review of the patient's notes

suggested the patient was likely suffering with sepsis, with the chest likely to be the focal point of infection. We noted the initial presenting NEWS score for the patient was three, despite the ambulance crew reporting the patient having experienced a postural drop in blood pressure whilst under their care to 60mmHg. The clinical history of the patient was consistent with a likely chest infection, however because the patients' NEWS was initially three, a sepsis screen was not automatically produced (local trust policy mandates a NEWS score of five would be the trigger for staff to complete a sepsis screen). The patient was held in the ambulance cohort area and then SIAN for a period of three hours before they were reviewed by a medic. The patient was then transferred to the high care area where the nurse reported having not received any handover of the patient and that no cannula was in-situ despite this being detailed in the medical treatment plan. Antibiotics and intravenous fluids were prescribed for the patient however it was noted on the drug chart that intravenous antibotics had not been administered for "Clinical reasons". Trust policy requires staff to record the reason why medicines are withheld for clinical reasons, however not record was included in the notes. It was therefore not clear whether the team were effectively managing the patients presenting condition within a timely way.

Patients waiting under the care of an ambulance crew for one hour or more are called a black breach. From January 2019 to December 2019, there were 3,591 black breaches in this service. This equated to approximately 11% of all ambulance attendances over the 12 month period and was consistently significantly worse than the England average of 5%.

There were good examples where patients being conveyed to the hospital with stroke like symptoms, were pre-alerted to the stroke team. In two cases, the stroke team undertook timely assessments of patients, including detailed treatment plans for patients. In one case, we noted an allied health professional had noted a patient was wearing nasal spec's but these were not connected to oxygen despite the patients clinical condition suggesting this was necessary.

Nursing staffing

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

The ED used a combination of the baseline emergency staffing tool and the National Institute of Health and Care Excellence (NICE) emergency department staffing recommendations, to ensure the department was staffed appropriately. This outlined how many registered nurses were needed to safely staff the department. The tools looked at the acuity of patients and how many were in the department at certain times of the day. As a result, the department had increased its staffing numbers to include additional staff being specifically allocated to looking after patients in the corridor. However, the trust had not increased the nursing workforce to ensure there were sufficient numbers of competent nurses working in the SIAN area to enable a timely assessment of patients to take place, as has been described above. Following the inspection, the trust reported they were intending on reducing the time nursing staff would instigate the GRAT from the existing 60 minutes to 30 minutes by increasing the nursing workforce to facilitate this. Whilst this reduction in time to assessment was to be an improvement from the trust position at the time of the inspection, it was still to be contrary to the national standard and regulatory condition imposed on the trust that all patients arriving by ambulance should be clinically assessed within 15 minutes.

There were not always enough nursing staff deployed to keep children safe from avoidable harm and to provide the right care.

The trust had a standard operating procedure which covered the children's area of the emergency department. The SOP stated that one nurse would be allocated at all times to provide care to children attending the ED. This nurse was to either be a registered children's nurse, or an adult nurse who had satisfactorily completed appropriate competencies relating the care of the sick infant, child or young person. During the inspection, a registered children's nurse was allocated and was supporting a student nurse who was on a clinical placement in the ED. We observed a period of approximately 10 minutes when the registered nurse was absent from the department, having been required to

transfer a child to the children's assessment unit, located elsewhere in the hospital. This meant the student nurse had been left alone and unsupervised in a high acuity clinical area, where six children were present.

We escalated this to the trust executive who reported that due to the SOP requiring sick children to be managed in the resuscitation area, the children's ED was not itself a high acuity area. Further, the trust reported that, in line with the SOP, they did not consider there to be a risk as the nurse-in-charge located in the majors area was to assume responsibility for the children's area, despite not being physically present in the department. The expectation within the SOP was that parents or carers would be required to escalate any concerns they had over the condition of their child to a member of the adult ED team should the allocated children's ED nurse not be present. We considered this to be an inappropriate escalation protocol as we recognise parents and carers are not always able to recognise the subtle changes to a child's condition and therefore there was a risk a child could have deteriorated and experienced a delay in receiving time critical care and treatment. It was apparent the children's emergency department standard operating procedure had not been sufficiently referenced against national standards including the Royal College of Paediatrics and Child Health - "Facing the future; standards for children in emergency care" guidance, issued in 2018.

Following the inspection we imposed conditions on the providers registration requiring them to ensure the children's area of the ED was sufficiently staff at all times and in line with national standards.

Medical staffing

Whilst there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care at the time of the inspection, consultant cover in the department did not meet recommended guidelines. Some doctors told us they needed more doctors in order to keep the department safe when it was overcrowded.

The department employed 6.7 whole time equivalent consultants with cover provided from 8am to midnight, seven days a week, in line with Royal College of Emergency Medicine (RCEM) recommendations. Whilst the department provided a service which met RCEM standards, this was achieved only through the commitment of the existing substantive consultant workforce and a reliance on locum consultants. At the time of the inspection, the department was funded to have 10 whole time equivalent consultants, as compared to the RCEM standard which recommended that for a department treating the number patients seen at Worcestershire Royal Hospital, 16 whole time equivalent consultants should be employed.

Consultants operated on a shift basis with one consultant present from 8am to 1pm, when they were then supported with a second consultant who worked from 1pm to 7pm (and then ordinarily became the overnight on-call consultant). A third consultant, who was often a regular locum, then worked from 4pm to midnight, allowing for there to be some overlap during peak periods. At weekends, one consultant worked from 8am to 5pm and a second consultant worked from 4pm to midnight, then providing an on-call service overnight.

Consultants were supported by a range of junior and middle grade doctors consisting of 3 specialist trainee (ST) level three grades; two ST level six grades; two clinical fellows and 5.2 trust grade doctors. Overnight, the department was staffed with one ST level four doctor; one ST level three doctor and two junior doctors. The view of the clinical director was the department required total of 16 middle grade doctors to ensure the department remained safe, especially during times of surge.

We observed good multi-disciplinary working between the nurse in charge and emergency physician in charge. Safety huddles occurred throughout the day during which department capacity, risk and staffing levels were considered. Whilst consideration was given to those patients who could not be offloaded from ambulances, or where patients experienced extensive delays, a lack of department flow and lack of capacity meant there were limited mitigations or actions agreed.

Inadequate

Urgent and emergency services

Are urgent and emergency services caring?

Requires improvement

Privacy and dignity

There were occasion's when staff did not treat patients with compassion, nor did they always do all that was reasonable to respect and protect their privacy and dignity.

We had previously reported that due to capacity challenges in the department, patients were cared for in areas which did not maintain their privacy or dignity. Whilst staff could demonstrate changes to practice including the introduction of ear plugs and night sleep masks for patients accommodated along corridors, we found on-going challenges which impacted on patient experience.

There was no privacy and little confidentiality for patients waiting on trolleys in the corridor. We had previously observed staff using privacy screens when undertaking procedures such as the taking of blood from patients on trolleys in corridors. At this inspection, we found privacy screens were not being consistently used. Phlebotomists were observed taking blood samples from patients without the use of screens for example. Staff further reported that whilst they had considered the use of screens, these had made it difficult to observe all the patients in the corridor, thus reducing safety.

We observed patients being moved temporarily to a curtained cubicle if they required urgent personal care such as an ECG. However, on one occasion, a patient experienced a delay of twenty minutes before an appropriate space could be found in order they could use a bedpan.

One elderly patient who had an obvious facial abnormality was relocated from a cubicle where they were afforded privacy, to directly in front of the SIAN station where they were in full view of others present in the department. Nursing staff worked to try and find an appropriate setting for the patient which would have provided sufficient privacy and dignity, however a lack of capacity in the department resulted in delays in this happening. This could have resulted in a poor experience for the patient. We further noticed an elderly patient who had remained on a trolley along the main corridor for approximately six hours. The patient was clearly uncomfortable however they remained unsupported until a member of the inspection team intervened and asked a nurse to help re-position the patient.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Inadequate

Access and flow

Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.

ED escalation levels were determined by the regional health economy Escalation Management System (EMS). EMS levels were graded one to four. EMS one is normal working, and three, is the department is under severe pressure. On the day of the inspection, the executive team reported the department was at EMS level three. Front line staff reported they were on operational pressure escalation level (OPEL) four. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care. The trust executive reported the system as being on OPEL two at the time of the inspection. National criteria define OPEL two as "Four hour access target being at risk of compromise; the local health and social care system is starting to show signs of pressure. The local accident and emergency delivery board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation". Further examples of OPEL two within the national framework are described as "Anticipated pressure in facilitating ambulance handovers; insufficient discharges to create

capacity for the expected elective and emergency activity; opening of escalation beds likely; infection control issues emerging; lack of beds across the trust; ED patients with Decision to admit and no action plan". OPEL three is described as "Four hour access target significantly compromised; significant numbers of handover delays; patient flow significantly compromised".

There was a disconnect between the executive team and the local team in regards to the level of escalation. This suggested poor communication between the two teams and was consistent with the views of front line staff. Staff working in the ED considered there was little input or support provided from specialty teams, especially during times of surge. The risk of such a disconnect occurring is that the ED staff may have expected additional support and interventions were being considered by the wider health economy to help reduce pressures in the ED itself and to help decompress the department back to a safe operational state. The fact the system was reported to be at OPEL two would suggest pressure relieving strategies were not being considered and therefore it was unlikely there would have been any noticeable improvement in the overall performance of the urgent and emergency care pathway.

NHS Trusts are required to monitor and report nationally the percentage of patients who attend ED and get seen, discharged or admitted within four hours of arrival. This is known as the Emergency Access Standard (EAS). The NHS standard requires 95% of patients to spend less than four hours in ED. Worcestershire Royal Hospital has consistently not met this target in any month between January 2019 and December 2019. On the day of the inspection, performance against the access target was reported to be 69%.

Median time from arrival to treatment (all patients)

Managers monitored waiting times and tried to make sure patients could access emergency services when needed and received treatment within agreed time-frames and national targets.The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard and was worse than the England average from October 2018 to September 2019. The median time to treatment ranged from 77 to 91 minutes.

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

Over the 12 months from November 2018 to October 2019, 843 patients waited more than 12 hours from the decision to admit until being admitted.

The trust reported that between January 2019 and December 2019 the aggregated average time it took for patients to be admitted to a ward 4 hours from arrival to the ED ranged between 804 minutes and 1,130 minutes.

A total of 23,211 patients spent more than six hours in the ED between January 2019 and December 2019.

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

From January 2019 to December 2019, the total percentage of patients who left the department before being seen for treatment was reported nationally as 0.0%. However, data provided by the trust following the inspection reported a total of 1,551 patients left the department before being seen. This equated to between 1.7% and 2.5% of patients leaving the ED without being seen each month.

We have previously reported general poor compliance with the trust's professional standards protocol. This requires that patients referred to specialty teams should be reviewed and clerked within one hour in order an appropriate plan of care can be determined for patients. Whilst the trust tracks each specialty in terms of their responsiveness, there had been no real improvement in the overall average time it took for patients to be reviewed:

- Jan 2019 - 146 minutes.
- Feb 2019 - 104 minutes.
- March 2019 - 102 minutes.
- April 2019 - 93 minutes.
- May 2019 - 90 minutes.
- June 2019 - 104 minutes.
- July 2019 - 109 minutes.
- August 2019 - 118 minutes.
- September 2019 - 139 minutes.
- October 2019 - 121 minutes.
- November 2019 - 119 minutes.
- December 2019 - 130 minutes.

Inadequate

Urgent and emergency services

The percentage of patients who were referred to a specialty team and who were reviewed within 60 minutes also showed a lack of sustained improvement over the 12 month period of January 2019 to December 2019:

- January 2019 - 42%.
- February 2019 - 46.9%.
- March 2019 - 50.4%.
- April 2019 - 51.1%.
- May 2019 - 49.9%.
- June 2019 - 46.5%.
- July 2019 - 46.4%.
- August 2019 - 48.5%.
- September 2019 - 38.2%.
- October 2019 - 42%.
- November 2019 - 42.2%.
- December 2019 - 41.3%.

The resulting fact of poor departmental flow was patients experiencing extended stays along the main ED corridor. We observed patients being cared for on trolleys throughout the department. Patients reported having trouble resting and this was apparent during the inspection. Patients were provided with blankets and pillows however due to the lack of privacy, the high level of foot traffic, and general noise levels, patients could not seek any respite or rest. Noise and light pollution had previously been raised as areas of concern and nuisance by patients. Whilst patients could be provided with ear plugs and sleep masks, these had little impact on the overall experience for patients.

There was on onsite GP service which was ran separately from the hospital. We observed the GP actively trying to direct patients from the ED streams through to the GP stream if the GP felt the patients' condition could be effectively managed in a less acute setting.

Are urgent and emergency services well-led?

Inadequate

Leadership and culture

Local leaders could describe the challenges faced by the department. However, despite a range of action plans and interventions to address on-going capacity and flow challenges across the organisation, there had remained very little change in the quality of the emergency care pathway provided at Worcestershire Royal Hospital.

Staff remained positive about trying to improve the quality of service at Worcestershire Royal Hospital. However, although there was a perception among staff that caring for patients on corridors was unacceptable, we concluded the practice had become normalised. New ways of working continued to be introduced as a means of trying to mitigate risks and to maintain patient safety. However, there was a lack of insight in to the ongoing challenges of the emergency care pathway from system leaders, the wider health system and the executive team. Staff working in the ED reported poor visibility of the executive team, with a lack of appreciation of the challenges faced by staff in the ED.

All staff were positive about working in the department. All staff were cheerful, friendly and engaged in conversations with patients, relatives and other staff. Staff demonstrated working to common goals and supported each other. Leaders and staff were committed to driving improvements in the service to keep patients safe from harm and to improve the experience of all patients using the service.

Doctors told us that there was a strong culture around the importance of formal and informal teaching within the department.

Interactions between all staff, even when the service was in extremis were positive and respectful. Staff listened to each other, and offered help.

Vision and strategy for this service

The service had a documented vision for what it wanted to achieve. Plans were being implemented to ease overcrowding in the department were in development with involvement from staff, patients, and key groups representing the local community.

There was both a trust wide and system wide plan for improving the flow of patients through the hospital. This included the opening of additional beds for general medicine patients. This was in addition to an additional

60 beds which had been opened earlier in 2019. The trust and wider health system had developed the "Home first Worcestershire" action plan. The plan had six work-streams including:

- SAFER patient flow and RED2GREEN
  - Processes which empower clinicians to advocate on behalf of patients to ensure that today's work is completed today. The process will identify key constraints and themes which require resolution. The net effect is an improvement in flow, a reduction of length of stay, earlier in the day discharge
- Primary Care Streaming
  - Streaming of patients appropriate for a primary care clinician, to the appropriate place.
- Clinical Site Management
  - A pro-active site management team ensure available beds are utilised effectively to place the right patient in the right place with an overview of site safety and risk
- Long Length of Stay Review
  - A systematic review of patients with a Long length of stay designed to unpick, unblock and escalate issues preventing progress of the patient plan. All Wards to be included in process
- Internal Professional Standards
  - Internal professional standards ensure specialty response times to the emergency department are reasonable so that patients are seen as quickly as possible to provide the best experience.
- Trust Workshop Outcomes
  - A Divisional team workshop was held on Tuesday 12th February 2019. The key outputs from the workshop form Project 7

The themes within the Home first Worcestershire action plan mirrored the themes identified from previous inspections. Actions within the plan were similar to, and in some cases identical to actions previously highlighted. We were not assured the organisation and wider health system had the necessary capacity and capability to deliver any meaningful change. A new system oversight board had been created however despite the approval for a programme director to be appointed, this role had not been advertised. Further, there existed a lack of urgency across the health system to drive change within the urgent and emergency care pathway.

It was not clear how the home first action plan would be delivered . Staff could not describe any effective quality improvement methodology. Further, where actions had been identified, these had not always been instigated. This included, for example, the ability to permit emergency care physicians to make admission decisions. This had been identified as an action for completion in April 2019 (as set out in the Home First action plan). We noted a system wide meeting in September 2019 had resulted in a decision being reached that emergency care physicians were to be granted with admission rights for emergency medicine cases. However, at the time of the inspection, emergency care physicians were not using these admission rights for fear of a lack of hospital capacity, therefore increasing the number of 12 hour breaches likely to be reported. The executive team were not sighted on this at the time of the inspection suggesting a lack of oversight of the emergency care pathway.

Governance, risk management and quality measurement

The service had a systematic approach to continually monitor the quality of its services. The service monitored activity and performance however this was not driving the necessary improvements.

Data relating to performance was clearly displayed in the unit. Staff openly discussed performance and what it meant for patients. Whilst new models of care and nursing assessments had been devised in an attempt to manage the safety of the department, there was a lack of awareness or consideration given to national quality standards. For example, the introduction of the global risk assessment tool had come in to being as a result of ambulances not being able to offload their patients in a timely way. Further, limited departmental capacity meant clinicians could not always see patients in a timely way. We noted that despite serious incidents having occurred in which patients had not been clinically assessed or treated in a timely way, there had been no drive to address this. The trust executive team took assurance from local GRAT audits despite these showing varied compliance. There had been no audit of whether the GRAT was consistently used according to trust policy in that all patients who experience a delay of 60 minutes of more from being handed over should be assessed

against the global risk assessment tool. The GRAT SOP had not been sense-checked against the national standards in that patients arriving by ambulance should be clinically assessed within 15 minutes and that patients should be seen by a senior clinical decision maker and care or treatment started within 60 minutes. Following the inspection, CQC imposed a condition on the providers registration requiring them to ensure patients were clinically assessed within 15 minutes. The trust responded by stating they would ensure patients were assessed against the global risk assessment tool within 30 minutes, therefore placing the trust at risk of breaching the newly imposed conditions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
Areas the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the hospital MUST take to improve to:

- The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that patients receive medical and specialty reviews in a timely manner. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that consultant and nurse cover in the department meets national guidelines. Trainee consultants must not be classed as 'consultants' on the staffing rota. Regulation 12 (c)
- Fully implement the trust wide actions to reduce overcrowding in the department. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that the privacy and dignity of patients receiving care and treatment in the emergency department is maintained at all times. Regulation 10 (1)

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The privacy and dignity of patients was not always maintained or protected. This was contrary to Regulation 10 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. We have imposed conditions on the trust's registration to ensure urgent improvements are made in the timeliness of assessment, care and treatment for patients.