

COVID-19 INSIGHT

Issue 9

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COVID INSIGHT

THE IMPACT OF THE PANDEMIC ON URGENT AND
EMERGENCY SERVICES



Introduction

In the [last edition of this Insight series](#), we looked at the evidence so far about how urgent and emergency care services have been affected by the pandemic during this winter, and discussed what action CQC has been taking to provide constructive support.

Part of this support was working with frontline clinicians from emergency departments to publish [the Patient FIRST framework](#) in October 2020, as a tool to help support those working in NHS trusts and the wider health and care system to understand learning from the pandemic and share good practice.

The framework contains a number of practical examples of actions that can be taken at a departmental, trust and wider system level to maximise capacity, maintain effective patient flow, and keep staff and patients safe.

During October and early November 2020 we applied our ‘transitional regulatory approach’, through which our inspectors held discussions with executive directors of trusts with major emergency departments around our key questions of safe, responsive and well-led.

Informed by the transitional regulatory approach process, the monitoring of situation reports data, and intelligence from local inspections teams, we have identified around 13 emergency departments for inspection from winter last year.

This article looks at the first five of those inspections, which took place between 30 November and 21 December 2020, seeking to identify the key factors affecting services’ ability to provide a good standard of care, as well the challenges they faced. The full inspection reports can be found on our website:

- Medway NHS Trust – [Medway Maritime Hospital](#)
- Norfolk and Norwich NHS Trust – [Norfolk and Norwich University Hospital](#)
- North West Anglia NHS Foundation Trust – [Peterborough Hospital](#)
- Pennine Hospitals NHS Trust – [Oldham Hospital](#)
- Wye Valley NHS Trust – [Hereford County Hospital](#)

The inspection reports emphasise the extremely challenging circumstances that providers have faced during the pandemic. This, combined with the fact that all of the inspections were based on risks, mean it is not surprising that inspectors identified concerns with waiting times, delays and other issues.

While the detail varied across inspections, the key factors identified as affecting services' ability to provide a good standard of care in emergency departments were:

- Environment
- Onward capacity
- Delayed transfers of care
- Staffing levels and staff absence
- Leadership and governance
- Systems to mitigate risk.

Environment

All of the hospitals were undergoing, or had recently undergone, physical changes to the urgent and emergency care departments, including the children's emergency department. This generally meant a change in the use of spaces to allow for the triage and streaming of patients down COVID and non-COVID pathways. These changes were constantly being reviewed to meet the changing number of patients attending with COVID.

There were examples of this working well, but for others it was causing confusion, and issues with crowding and the ability to social distance. This had an impact on flow and, in turn, delays.

In one department a 'warm pathway', designed for people with possible symptoms but no diagnosis, had set up rapid testing. However, as only three tests could be completed per hour, and the average wait for a result being four hours, this was causing delays and risk of exposure to COVID-19.

Two of the hospitals were struggling with the triage and assessment of patients. Inspectors found the process was not well-embedded and witnessed patients waiting too long for triage and ineffective systems to identify if patients were in pain or deteriorating. Assessments were not always done while people waited to be admitted, treated or discharged, which meant they were at increased risk of harm, for example pressure damage to patients' skin.

Most of the departments were not queuing or cohorting patients in corridors to avoid overcrowding and maintain social distancing during the pandemic. However, this had a knock-on effect on ambulances. Patients were being held in ambulances, either awaiting treatment or until a place on a ward could be found.

The implementation of rapid assessment and treatment (RAT) systems was helping to address problems in some departments. However, progress was slow in one case, with just under half of patients not meeting the hospital's 15-minute handover target in December 2020. At another hospital there were long ambulance handover delays where medical and nursing staff were not able to ensure patients waiting in the ambulances always received timely clinical intervention. The delays also had an impact on ambulance crews' wellbeing and their ability to respond to other patients in the community.

At one hospital, inspectors did witness queuing in corridors. They raised concerns, as this did not allow for adequate social distancing and, at times, patients' privacy and dignity was compromised. In another, the children's emergency department did not allow for a one-way system and the corridors were too narrow to allow for adequate social distancing.

In some departments, reconfigurations had caused problems for mental health services. For example, a safe and private room for patients presenting with mental health needs was now being used as an area to don and doff personal protective equipment, and the identified replacement was not suitable. A similar situation was found at another department where a repurposed 'plaster room' was not fit for purpose as a mental health 'privacy room'.

There were positive examples where trusts had put in place systems or mitigations to improve the impact on patients, for example:

“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.”

“Due to the small size of the department, while some areas were permanently ‘green’ or ‘blue’, others changed according to the proportion of patients categorised as ‘green’ or ‘blue’ as it altered throughout the day. This was done against a written standard operating procedure. We found this system effective and intuitive.”

The trusts in these examples were seen to have good processes for triage and assessment to ensure patients were seen in an appropriate order. We also saw ongoing monitoring to ensure that any deterioration in patients’ conditions, while they were waiting, was identified and responded to swiftly. One member of staff described their pride in the new triage system, which had created more space and improved patient flow.

Onward capacity

At all the hospitals inspected, inspectors found that the wider capacity of the hospital was a factor on delays in the emergency department.

Hospitals wards were operating routinely at capacity, often having been reconfigured themselves to allow for the social distancing and streaming requirements of the pandemic, and this was affecting patient flow.

“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 emergency department and the wider hospital.”

There was one example of a patient who had spent 19 hours in the emergency department as they waited for a side room to become available on a ward. At another, inspectors saw three people waiting for an inpatient bed. They were told by nursing staff that there were lengthy delays for patients waiting for an inpatient admission, due to limited bed flow. They said this was across the trust as a result of limited daily discharges. The increased number of patients in departments waiting for admission meant that other patients could wait longer to be seen and treated because of the impact on space and staff availability.

Delayed transfers of care

Incidents of delayed transfers of care were part of the flow problems in hospitals. The factors explicitly referenced in these inspection reports that prevented patients moving on were:

- waiting for patient transport
- delays in discharging patients into the community
- delays in COVID-19 testing to enable discharge to an external care provider.

Transfers from A&E to external mental health providers was an issue for one department. The waiting time for a crisis bed and for travel arrangements to be made could take between two hours and three days.

These issues tended to be problems outside of the emergency department, but caused flow problems that impacted on their performance.

Staffing levels and staff absence

Some of the hospitals we inspected were not able to meet the intended staffing levels due to a shortage of staff. At some, this shortage was attributed to recruitment and retention issues and staffing levels were maintained through using locum doctors and agency staff.

Other hospitals were experiencing increased levels of sickness and absence linked to the pandemic. Incidents of self-isolation, shielding requirements, positive COVID cases and staff absence due to stress and anxiety directly impacted on some hospitals' ability to cover all the shifts in the emergency department.

“Staff told us there were frequent closures of assessment areas, often due to staff shortages, which contributed to increased delays in the emergency department. Managers told us the surgical assessment unit was frequently blocked and at the time of the inspection, the clinical decision unit was taking no patients due to a lack of staff.”

The staffing challenges in the emergency department were causing delays. Inspectors were told of an example where staff shortages at night placed additional pressure on incoming staff, with higher numbers of patients in the morning and delayed discharges. Other issues were the ability of staff to access senior staff for support, and the capacity to progress initiatives designed to reduce delays, such as pathway development. One hospital had a mitigation plan where it reduced or cancelled medical training to increase staff availability and provide clinical cover.

Other impacts were on staff morale, with some staff describing how it affected their ability to provide well-timed care, as well as feeling unsupported by other departments and the executive team.

Leadership and governance

All the themes identified so far link back to the leadership and governance at the services, the oversight they had, and what actions and mitigations they were taking to manage the risk. Some hospitals did have oversight and risks were well managed.

“We reviewed the emergency department (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.”

However, at other hospitals there was no clear governance structure in place and risks were not effectively managed.

“Managers were able to describe the three biggest risks to the department. However, the team did not include recurring delayed handovers of patients from ambulance crews as one of their biggest risks. Although they were aware of the issue, they did not appear to take ownership of the risk or have a system to mitigate it.”

In practice this meant inspectors witnessed site meetings that didn't result in any actions for patients who had been in the department for 12 hours, illustrating clearly how poor oversight and governance contributed to the delays.

Another hospital had defined the risks in the emergency department. There was a governance route and documented evidence of root cause analysis, lessons learned and action plans; however actions then remained outstanding. Similar situations were found at other hospitals where the actions taken to try and address known risks and issues were not always effective.

Findings were polarised on the standard of leadership and culture across the services. In some services leaders were visible and approachable and staff spoke positively and with pride about working in the department. At others, staff felt unsupported by the executive team and low morale was a problem.

Systems to mitigate risk

Most of the hospitals had appropriate systems and new initiatives in place to try and address the challenges in their emergency departments. Inspectors were told of regular on-site meetings and designated posts in the department to address and anticipate demand. An example of this working in practice is described below.

“Appropriately senior staff were present, and the meeting was organised and well chaired. At the time of our inspection, the department and the hospital were experiencing stress from the number of patients attending. The meeting noted that the emergency department's majors area was full, and that the department was 'just coping'. Because it was expected that the department would reach capacity later in the day, staff were reminded

of the standard operating procedure to enable patients to be cared for in the corridor or waiting ambulances. The planned staffing level for the nightshift was in place, but because of the expected demand the status was flagged as ‘amber’ and two additional members of nursing staff were requested.”

There was work to develop pathways to identify clear routes for patients, but also to divert patients from A&E to more appropriate or specialised treatment.

“There were a variety of pathways to enable patient flow, including same day emergency care for non-frail acute medicine, surgical assessment unit, gynaecology assessment unit, and a primary care service, depending on the need to reduce admissions and support earlier discharges.”

Much of this, however, was still in development. Some examples, such as the ‘navigation project’, are detailed below.

Some had digital systems to track patients through hospital, which helped with patient flow. There were standard operating procedures to address known issues. Examples of these were also seen in action and illustrated the pressures departments were facing.

“There were standard operating procedures in place to allow patients to be cared for in ambulances or, in extremis, in the corridor should the emergency department capacity be exceeded. Observed in practice on the day, there was a situation that meant patients were unable to be sent to a ward as planned because of an emergency that was taking place on the ward.”

Some of the hospitals were demonstrating good partnership working with ambulance trusts. Emergency department staff worked with hospital ambulance liaison officers (HALO) to support patient flow. Ambulance crews could pre-alert departments to the arrival of certain conditions and be greeted by HALO to divert patients for speedy treatment. They attended hospital meetings to support good communication and could oversee patients in corridors during busy times so ambulances could be released.

However, inspectors often found staffing pressures and increasing demand had an impact on the effectiveness of many of these systems.

“The leaders described the initiatives the service was implementing internally, such as the new nurse co-ordinator role in the department and in-reach from medical consultants and therapy teams. Similarly, they described initiatives with external partners to reduce demand on the service, including a range of community and primary treatment pathways to deflect patients to more appropriate care services, and to improve flow within the hospital and the department. However, we did not see these reflected in the service’s key performance figures which, due to increasing demand on the service, were continuing to deteriorate.”

“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).

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.”

Inspectors also saw initiatives that were yet to be fully embedded or ‘currently under-utilised’, which meant any impact on performance was yet to be seen.

COVID INSIGHT

SAFE AND EFFECTIVE USE OF MEDICINES IN NHS TRUSTS



Introduction

Pharmacy services are a crucial activity in NHS trusts, helping to ensure people can access their medicines and receive support to take them. CQC's Medicines Optimisation Team engages with chief pharmacists and those who are accountable for medicines optimisation in NHS trusts across England. This forms part of CQC's ongoing monitoring of trusts and helps to assure us that trusts' pharmacy services are facilitating safe, effective and person-centred care. Medicines optimisation is the safe and effective use of medicines to enable the best possible outcomes for people.

To understand how trusts were assuring themselves of safe medicines practice during the pandemic, we carried out a programme of virtual supportive conversations with chief pharmacists and medicines optimisation leaders within trusts between July and October 2020. Nearly all (98%) of the acute, community, mental health and ambulance NHS trusts participated in these conversations.

Even though pharmacy teams were exceptionally challenged, chief pharmacists told us how they assured themselves that they had oversight and systems in place to identify and minimise risks.

This article describes the challenges they faced, the good practice they had in place, and learning that can be taken forward.

Patient focus

Vulnerable patients and access to medicines

Chief pharmacists told us they developed various solutions to ensure that patients continued to have safe access to medicines prescribed in outpatient clinics when they needed it, particularly for patients who were more vulnerable, such as those who were shielding. Examples included:

- home delivery
- “drive thru” set-ups (for both supplying medicines and monitoring them, such as blood tests)
- using volunteers or re-deployed staff
- sending prescriptions directly to patients for dispensing in community pharmacies
- trialling the Electronic Prescription Service (EPS).

Many trusts had received positive feedback about changes to outpatient services and were looking to maintain them as business as usual.

Patient feedback

A small number of trusts said they actively asked patients for feedback when they made changes to pharmacy services. Some stated that they received feedback, including through their Patient Advice and Liaison service, and were happy to respond to concerns raised.

Others gathered feedback from national initiatives, like the ‘friends and family test’, but recognised that these were not specific to medicines. In some cases, there was a lack of insight into the value that feedback could provide.

A few pharmacy teams were creative in seeking out patients’ voices. This included using virtual platforms for patient focus groups to discuss changes to services.

Use of technology

The use of technology improved ways of working, not only in pharmacy teams, but also in multidisciplinary teams and within local health and care systems.

Chief pharmacists told us that services with more advanced technology were able to maintain oversight of clinical pharmacy more easily. However, some chief pharmacists said that not being able to have a face-to-face review of medicines with a patient made it harder to identify any recent changes to their medicines.

Some examples of innovations to minimise face-to-face contact included:

- virtual daily huddles to transfer information efficiently
- medicines reconciliation calls by telephone with patients or ward staff to ratify information and ensure the most recent medicines were prescribed
- virtual ward rounds
- virtual training and handovers for re-deployed or re-joined staff
- recording virtual staff updates for those who could not attend to watch later.

Conversely, challenges raised included:

- lack of guidance on medicines on some electronic systems due to the trust's IT infrastructure
- not being able to order controlled drugs electronically
- problems for clinicians when working from home when homecare services used paper prescriptions
- delays in receiving the right IT equipment for staff working from home.

Trusts said they were at different points in procuring and setting up electronic prescribing and medicines administration (EPMA) systems, to replace more traditional methods. Those who did not have EPMA believed that it would have been useful in helping a more seamless response to the first wave of the pandemic.

We were told that providing a clinical service was extremely challenging for trusts that still used paper-based systems.

Workforce

Wellbeing

Chief pharmacists were unanimously proud of their teams and reflected on how their teams had “stepped up”, adapted and gone “above and beyond” in difficult and stressful times to maintain services and support patients with their medicines.

Some teams received positive feedback from their trust, recognising how integral they were in response to the pandemic.

Where leaders took an inclusive approach in seeking and listening to the views and experiences of all staff, teams were empowered to make improvements.

Capacity

Hospital pharmacy teams provide highly specialised services for patients. They require very specific training and experience to carry out the work to a high standard. Chief pharmacists told us that the pandemic has brought into focus the sustainability of these services.

They gave examples, which included the following:

- some aseptic services, such as the preparation of pre-filled syringes of medicines for patients in critical care units, were suspended due to staff shortages
- some trusts trialled reducing ward-based clinical pharmacy in favour of a virtual service to reduce footfall, but also due to reduced capacity. However, some chief pharmacists told us that ward-based multidisciplinary teams asked for pharmacy staff to return to the wards
- increased demand meant that some trusts extended their pharmacy opening hours and implemented seven-day working. This posed a challenge where resources were limited.

The pandemic meant that pharmacists in their pre-qualification training year (pre-registration pharmacists) were not able to take their registration exam in June 2020 and qualify as fully registered pharmacists. This created a workforce capacity challenge for many trusts.

To minimise this challenge, a temporary provisional registration status was granted to pre-registration pharmacists by the General Pharmaceutical Council. This allowed them to carry out certain activities with limits. Chief pharmacists were grateful for their support and recognised their efforts.

Leadership and governance

Governance

Many pharmacy teams were well embedded into their trust's governance and communication frameworks.

Where this was not the case, we were told about pharmacy teams experiencing significant challenges, including:

- problems with quality assurance processes
- staff not always being consulted about changes (including services being suspended) or new policies that could have an impact on their work
- staff not being asked to help with contingency planning for the future towards the end of the first wave of the pandemic.

We heard that in some cases, learning and reflections from the challenges experienced helped to strengthen relationships and raise awareness of the crucial work that pharmacy teams undertake.

Many chief pharmacists told us that medicines incident reporting had decreased at some point during the first wave of the pandemic. We asked how trusts responded to incidents to mitigate risks to patients. They told us that learning from incidents was shared within trusts and through wider networks.

Controlled drugs

The requirement for physical (not electronic) signatures for controlled drug prescriptions and ordering created practical challenges for providers, for example when prescribers were working from home conducting virtual clinics. Most providers told us they created patient-centred solutions, having risk-assessed the possible impact of these. However, chief pharmacists were concerned that there was less opportunity to consult a fuller range of stakeholders about decision making for these processes, and that they could be time consuming. We were also told that the requirements for physical signatures on prescriptions at discharge led to delays in people being able to leave hospital.

Chief pharmacists also raised concerns about a lack of knowledge among wider teams around controlled drug legislation relating to storage, particularly when wards were re-organised or moved, or when controlled drugs had to be transported with patients, both within and between providers.

Working together as a system

Chief pharmacists experienced challenges in working with other organisations as a local health and care system, but most said that the response to COVID-19 had either initiated or accelerated collaborative working and improved communication.

This often meant changing how they worked with different providers or organisations. For example, trusts told us about some of the work they did to help support care homes, including weekly support calls as well as visits if needed.

National guidance

While national guidance was welcomed, chief pharmacists said the way information was published and disseminated could be improved. We were told that trusts often made initial decisions themselves and then, when national guidance became available, they reviewed, adapted or adopted their decision. This led to duplication of work.

Messages were sometimes viewed as contradictory and confusing, requiring teams to be constantly updated and trained, which added to fatigue and pressure. Others thought that much of the guidance was not produced with their 'type' of trust in mind, such as community and mental health trusts.

Medicines supply

Procurement

Pharmacy procurement teams were vital in maintaining supplies of medicines in response to the pandemic. Many started to work from home to reduce the risk of COVID-19 infection, while maintaining capacity and supply.

Good practice included:

- automated dashboards, which gave a real-time view of medicines in stock
- bespoke checklists for rapid review of critical medicines.

Trusts told us that, due to the demand of the pandemic, at times, some medicines were in critically short supply. However, collaborative working and enhanced communication within the trust and the local system meant that, overall, supplies were maintained.

Oxygen

The pandemic led to an increase in demand for oxygen. Chief pharmacists said they assured themselves that all patients had adequate access to oxygen through good collaboration between pharmacy teams, facilities teams and external providers.

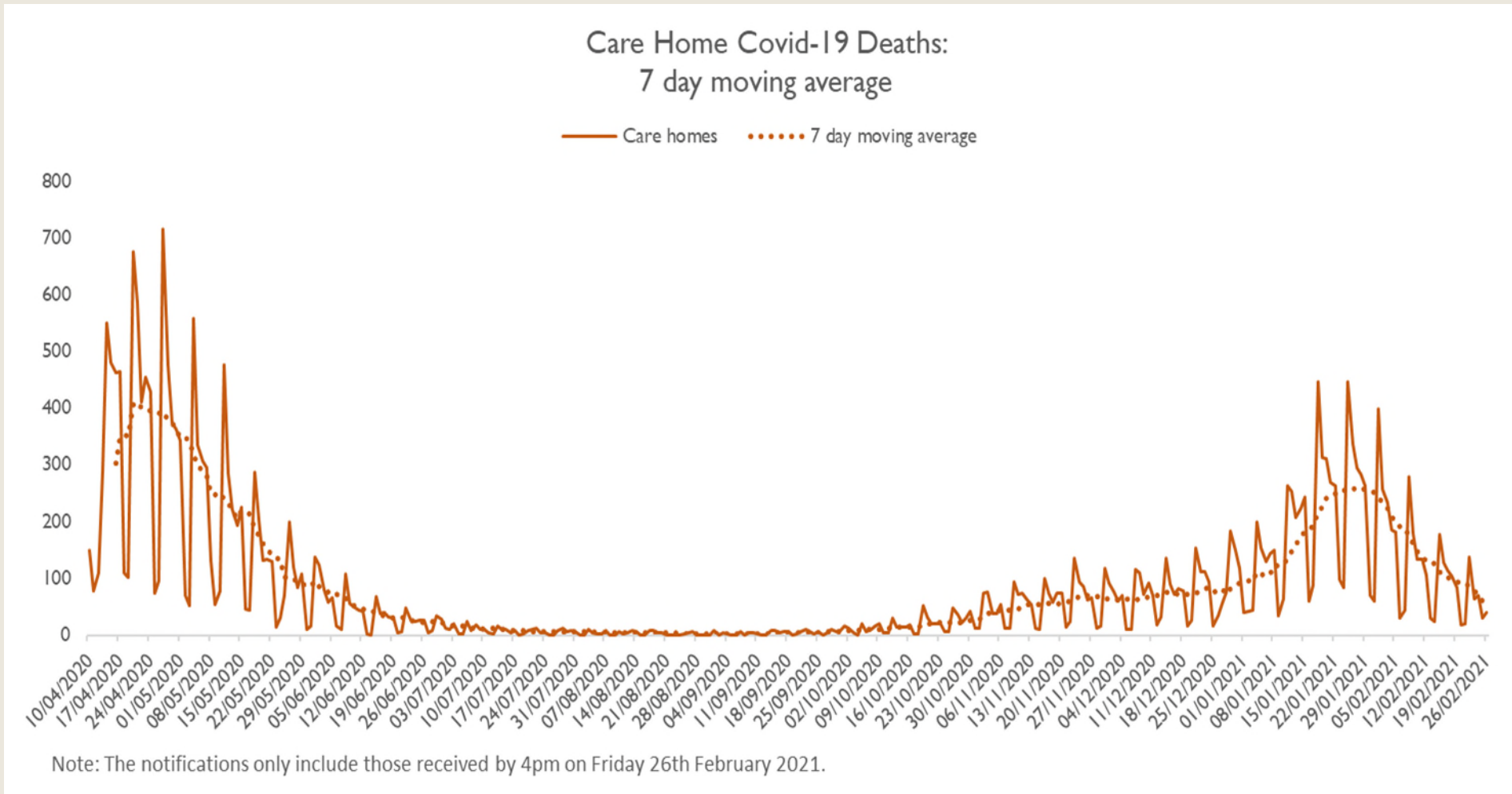
This collaboration was particularly needed where, prior to the pandemic, trusts had business cases awaiting approval for upgrades to their oxygen supply systems, which quickly needed to be actioned to meet new demand. They also said that the increased demand for oxygen through pipes, cylinders or concentrators occasionally had an impact on ward layouts, patient flow and delayed discharges.

COVID INSIGHT

DATA APPENDIX



Deaths notified by care homes



The chart shows the number of death notifications of people in care homes flagged with COVID-19 submitted each day up to 26 February 2021, with a seven-day moving average line showing the smoothed trend. The numbers of deaths appear to have peaked in mid-January and have been steadily falling since then.

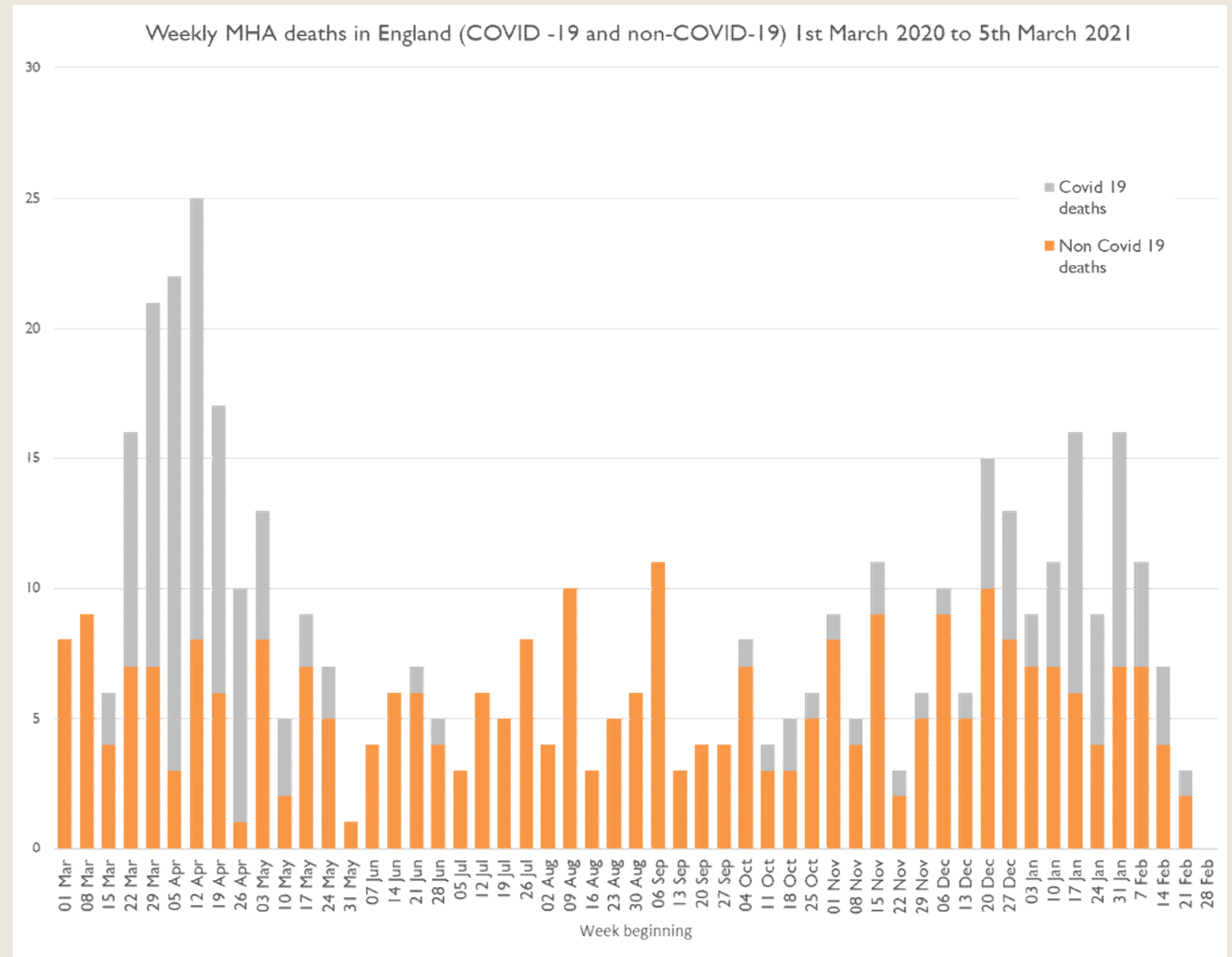
Deaths of people detained under the Mental Health Act

All providers registered with CQC must notify us about deaths of people who are detained, or liable to be detained, under the MHA.* From 1 March 2020 to 5 March 2021, we have been notified of 159 deaths that mental health providers indicated were suspected or confirmed to be related to COVID-19 (an increase of 15 since we reported in February). A further seven COVID-19 related deaths of detained patients were reported by other (non-mental health) providers (no increase since we last reported).**

The chart shows the number of deaths by week of death.

* Includes detained patients on leave of absence, or absent without leave, from hospital, and conditionally discharged patients. 'Detained patients' also includes patients subject to holding powers such as s. 4, 5, 135 or 136, and patients recalled to hospital from CTO. These counts may also include notifications about the deaths of people subject to the MHA who are in the community and not in hospital.

** Data on notifications may be updated over time and therefore successive extracts may lead to changes in overall numbers unrelated to new cases.



Deaths of people detained under the Mental Health Act (cont.)

Of the 458 notifications from mental health providers in the 2020/21 period (covering all causes of death from 1 March 2020 to 5 March 2021), 360 were from NHS organisations, of which 121 deaths were indicated as being COVID-19-related, and 98 were from independent providers, of which 38 deaths were COVID-19-related.

We have identified 28 detained patients whose deaths have been notified to us from 1 March 2020 to 5 March 2021 who had a learning disability and/or were autistic: the majority (17) were not identified as related to confirmed or suspected COVID-19. Of these people, most also had a mental health diagnosis. Please note that these patients were identified both from a specific box being ticked on the notification form and a review of diagnoses in the free text of the form.

The table below shows all deaths of detained patients from 1 March 2020 to 5 March 2021, by age band and COVID-19 status.

Age band	16-17	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Unknown	Total
Suspected or confirmed COVID-19		1	4	8	11	28	35	46	22	11	166
Not COVID-19	1	13	30	27	40	53	53	49	18	40	324
Total	1	14	34	35	51	81	88	95	40	51	490

Deaths of people detained under the Mental Health Act (cont.)

The table below shows all deaths of detained patients from 1 March 2020 to 5 March 2021, by gender and COVID-19 status.

Gender	Female	Male	Unknown or unspecified	Total
Suspected or confirmed COVID-19	55	98	13	166
Not COVID-19	98	182	44	324
Total	153	280	57	490

Deaths of people detained under the Mental Health Act (cont.)

The table below shows all deaths of detained patients from 1 March 2020 to 5 March 2021, by ethnicity and COVID-19 status.

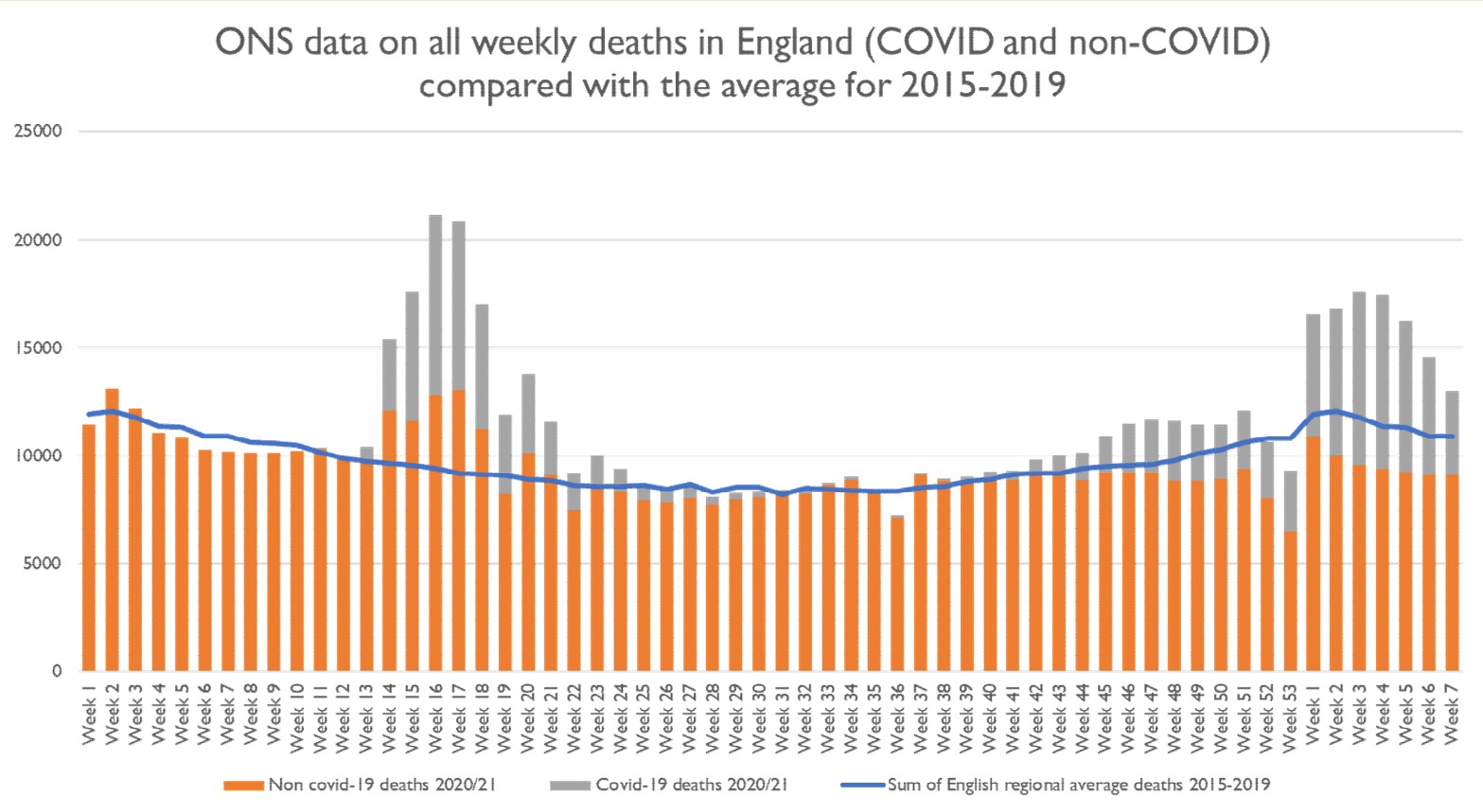
Ethnicity	Suspected or confirmed COVID-19	Not COVID-19
Asian	7	7
Black	19	26
Mixed	4	5
Other ethnic groups	1	3
White	94	195
Unknown	32	76
Not stated	9	12
Total	166	324

Deaths of people detained under the Mental Health Act (cont.)

The table below shows all deaths of detained patients from 1 March 2020 to 5 March 2021 by place of death and COVID-19 status.

Place of death	Suspected or confirmed COVID-19	Not COVID-19
Medical ward	112	100
Psychiatric ward	39	104
Hospital grounds	1	6
Patient's home	0	28
Public place	0	6
Other	3	41
Not stated	11	39
Total	166	324

ONS data on all weekly deaths in England (COVID and non-COVID) compared with the average for 2015-2019



Source: ONS COVID/non-COVID 2020 and 2021 death data:

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard>
 and 2015-2019 death data from:
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/11674fiveyearaverageweeklydeathsforenglishregionsandwalesdeathsthatoccurredbetween2015and2019>

Week 7, 2021: week ending 26 February 2021