NHS
North East and
North Cumbria

Item: 16

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official		Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	

BOARD 28 JANUARY 2025	
Report Title:	**Monitoring of Quality and Safety in urgent and emergency departments across the system.**

Purpose of report

To provide the ICB Board with an update on the ICB's monitoring of quality and safety in urgent and emergency departments.

Key points

In September 2024, NHS England wrote to NHS trusts and Integrated care boards to confirm the priorities over winter. The letter detailed priorities about providing safe care over winter including managing capacity and demand and taking all possible steps to maintain and improve patient safety and experience as an overriding priority. Additionally, at the same time NHS England produced some guidance on the principles for providing safe and good quality care in temporary escalation spaces (TES).

The commitment to patient safety during the winter period was further re-emphasised in a letter from NHS England and jointly signed by regulators including the Care Quality Commission, the Nursing and Midwifery council and the General Medical Council on 18 December 2024. The letter highlighted that 'Patient safety is, as always, the absolute priority for all staff within the multiprofessional NHS team, and that needs to be factored into any decisions about how best to manage and support patients and other service users.'

Data from the Royal college of Emergency Medicine (RCEM) indicates that waits of over 5 hours in emergency departments (ED) patient harms occur, and for over 12 hours there is an increased mortality risk. RCEM identify that for 12 hour waits there is one extra death for every 72 patients, equating to 300-500 excess deaths nationally per week. A report published by Imperial College London on the national state of patient safety 2024, highlights the adverse effects of medical treatment which led to death or disability, was twice as high in the North East of England than in Greater London. The North of England also had a higher number of trusts, reporting a greater than expected number of deaths, a figure that had increased to 14% from 8% in 2022.

The ICB has developed an approach to monitor quality and safety within urgent and emergency departments over the winter period, with joint working between the quality team and system resilience team. The approach has been developed to understand and maintain regular oversight of the pressures and quality risks within urgent and emergency care services across the NENC ICS, and to ensure prompt action is taken in response to patient safety risks.

Dedicated staff have been identified from the Quality team, led by a Head of Quality Governance and Assurance, to monitor patient safety incidents and attend system calls to understand the pressures within the region. The process and prompts have been aligned to the temporary escalation spaces (TES)

guidance from NHSE, the fundamental standards of care, and the managing risk guidance across the system (NHSE).

The ICB has shared the process across the NENC system and wider with the other trusts and ICB's in Yorkshire and Humber at the request of NHSE. Additionally, NHSE has asked the other ICB's to implement a similar process to the NENC process across their systems.

Themes across the ICS have been shared in the weekly executive summary report of incidents and at the UEC network strategic board meeting. Further work is currently being undertaken to develop a summary of key themes and trends from; incidents, through system meetings, and from implementing our assurance process, which will result in a monthly report to share learning and support improvement, starting in January 2025.

To support the timely sharing of learning, the quality team share key issues on the daily system co-ordination call. In addition, through our system co-ordination centre (SCC), the Quality team led by the Director of Quality, are setting up weekly meetings, with patient safety leads/ specialists and executives in trusts to share learning, flag any issues and understand assurance around quality and safety in ED. These meetings started on 20 January 2025.

The Royal College of Nursing published a report on the 16 January 2025, describing more than 5,000 nursing staff's experience of delivering care in urgent and emergency departments under significant pressures. These findings corelate with some of the concerns raised within the NENC system we have identified since implementing our process.

Risks and issues

- Whilst the ICB fully establishes and embeds this process and the reporting to share learning, systemic improvement work may be delayed. However, this is partly mitigated with the work the ICB Quality team/ system resilience team is undertaking with individual trusts and organisations.
- Continued pressures over winter, means trusts at times are operating under significant pressures, which exposes patients to increased risks of harm.

Assurances

- The ICB has developed an approach to understand and maintain regular oversight of the pressures and quality risks within urgent and emergency care services across the NENC ICS, to ensure prompt action is taken in response to patient safety risks.
- The ICB quality team have developed a robust system to identify key patient safety themes and trends in relation to urgent and emergency care, with prompt escalation to ensure assurances and oversight are sought.
- The ICB are working collaboratively with trusts to ensure continuous improvement in relation to patient safety concerns and reducing the risks of re-occurrence.

Recommendation/action required

Recommendations/ action required.

The Board is asked to receive the report for information and discussion, and to note the assurances and the work being undertaken by the ICB specifically: -

- The actions taken to date to develop the ICB's approach to monitoring quality and safety within urgent and emergency care over the winter period.
- The next steps to develop mechanisms to share learning with trusts through weekly meetings, with a purpose to share learning, flag any issues and understand assurance around quality and safety in ED.
- The ICB has implemented the process twice within December 2024, and have received both responses and were assured. One trust has asked for further support around discharges.

Acronyms and abbreviations explained
N/A

Supporting documentation (e.g. minutes from subcommittees)	
Presentation	
Sponsor/approving executive director	Ann Fox, Interim Executive Chief Nurse Neil O'Brien, Chief Medical Officer
Date approved by executive director	21/01/2025
Report author	Sarah Dronsfield Director of Quality

Link to ICP strategy priorities (please tick all that apply)	
Longer and Healthier Lives	✓
Fairer Outcomes for All	✓
Better Health and Care Services	✓
Giving Children and Young People the Best Start in Life	✓

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed. (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**	✓	**No**		**N/A**	

Key implications	
Are additional resources required?	**Quality team utilised**
Has there been/does there need to be appropriate clinical involvement?	**Provider Chief Nurses and UEC Network**
Has there been/does there need to be any patient and public involvement?	**n/a**
Has there been/does there need to be partner and/or other stakeholder engagement?	**NENC Provider Chief Nurses, UEC Network, NHSE NEY**

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The ICB's monitoring of quality and safety in urgent and emergency departments

Introduction

In September 2024, NHS England wrote to NHS trusts and Integrated care boards to confirm the priorities over winter. The letter detailed priorities about providing safe care over winter including managing capacity and demand and taking all possible steps to maintain and improve patient safety and experience as an overriding priority.

Additionally, at the same time NHS England produced some guidance on the principles for providing safe and good quality care in temporary escalation spaces (TES). Specifically, the guidance states that TES is not acceptable and should not be considered the standard, however whilst recognising that providers have had to use TES spaces. The guidance is aimed at supporting staff provide the safest, most effective, and highest quality care they can, when TES has been deemed necessary.

The guidance states that the fundamental standards of care (part of the health and social care act 2014) which CQC regulates against should be adhered to; these are the standards that are identified as care must never fall below.

There are also some exceptions to the use of TES spaces, these include: -

- Patients admitted with mental health concerns should be automatically excluded. The ICB has also widening this exclusion criteria to include patients with a learning disability and autism.
- Paediatric patients should also be automatically excluded.

The commitment to patient safety during the winter period was further re-emphasised in a letter from NHS England and jointly signed by regulators including the care quality commission, nursing and midwifery council and the general medical council on 18 December 2024. The letter highlighted that 'Patient safety is, as always, the absolute priority for all staff within the multiprofessional NHS team, and that needs to be factored into any decisions about how best to manage and support patients and other service users.'

Data from the Royal college of emergency medicine (RCEM) indicates that for waits of over 5 hours in ED patient harms occur, and for over 12 hours there is an increased mortality risk. RCEM identify that for 12 hour waits there is one extra death for every 72 patients, equating to nationally 300-500 excess deaths per week.

A report published by Imperial College London on the national state of patient safety 2024, highlights that the adverse effects of medical treatment which led to death or disability, was twice as high in the North East of England than in Greater London. The North of England also has a higher number of trusts reporting a greater than expected number of deaths a figure that has increased to 14% from 8% in 2022.

ICB approach to monitoring quality and safety

The ICB has developed an approach to monitor quality and safety within urgent and emergency departments over the winter period, with joint working between the quality team and system

resilience team. The approach has been developed to understand and maintain regular oversight of the pressures and quality risks within urgent and emergency care services across the NENC ICS, and to ensure prompt action is taken in response to patient safety risks. Dedicated staff have been identified from the Quality team, led by a Head of Quality Governance and Assurance, to monitor patient safety incidents and attend system calls to understand the pressures within the system.

The process and prompts have been aligned to the TES guidance from NHSE, the fundamental standards of care and the managing risk guidance across the system (NHSE). The process includes the following: -

- **Responsive quality assurance flow chart**- the process detailed with specific risks and actions identified.
- **Assurance request letter (acute and ambulance)-** as part of the process where there are triggers including incidents, excess waits, or ambulance handover delays, a verbal discussion with the trust will take place, and the quality team will send out a letter requesting assurance on the following areas.
- **UEC safety assurance visit (Responsive quality assurance review RQAR)-** If an assurance visit is needed, the ICB has developed the tool to support our staff with prompts and to ensure we take a consistent view around quality and safety issues. We know this will be amended and tweaked as we use it and from what we find. This covers patients and service oversight, including: -
    - Patients prompts- on safeguarding, IPC, environment and equipment, medicines, meeting patients care needs, assessing and responding to patient risk, and nutrition and hydration.
    - Service oversight prompts- escalation processes, flow (including within the department, clinical management, and oversight, waiting room oversight, flow to out of hospital services, senior leaders/ exec oversight of the dept), incidents and raising concerns (including whistleblowing), staffing, and ambulance handovers.
    - The prompts are aligned where appropriate to NHSE- principles for providing safe and good quality care, the fundamental standards of care (HSCA) and NHSE Principles for assessing and managing risks across integrated care systems.
- **RQAR feedback letter-** the ICB will send this post an onsite visit- highlighting areas of good practice and areas for further work and improvement.

Further work is being undertaken to develop prompts and an assurance letter for MH trusts about how they are and can support quality and safety within urgent and emergency departments.

Since the development of the process, the ICB has sent two letters to trusts seeking assurance about quality and safety in their departments. These have been due to: -

- Trust 1- long delays in ambulance handovers, deflections and diverts, management of patient flow including escalation of deteriorating patients, and waiting times in ED,
- Trust 2- in response to a specific patient safety concern, where a patient deteriorated whilst in a waiting area and the patient had not been handed over to ED staff.

Sharing the process

Within NENC

The ICB process was developed in mid-November to support the consistent and robust monitoring of quality and safety during the winter period. Within NENC, we have shared the approach with NENC NHS trusts Chief Nurse meeting on 30 November 2024, and the UEC network strategic

board meeting on 19 December 2024. There have been some comments to add additional prompts, but the process and supporting documents has been supported across the system.

To facilitate and support learning and continuous improvement in the quality of services, through our system co-ordination centre, the ICB has shared the above documentation and prompts with all our NHS trusts.

Wider NE region (NHSE)

Following a request from NHS England to all four ICB's in the NE region, the ICB shared our approach with NHSE and the other ICB's. As such the NHSE regional team, asked the ICB to present our process to all ICB's and NHS trusts in Yorkshire, Humber, and the North East, on 12 December 2024. The feedback was positive about the process the ICB has implemented, NHSE has asked the other ICB's to implement a similar process to the NENC process.

The other three ICB Chief Nurses and NHSE regional team, want a further discussion about our process, the implementation of this and how we can share our learning and improvements; a meeting is planned on 08 January 2025. We have also been approached by a couple of NHS trusts in Yorkshire to discuss quality and safety in ED.

Learning and supporting improvement across the system.

As part of our learning and identification of patient safety concerns over the winter period, the ICB have identified the following patient safety concerns: -

- Trusts are not always incident reporting 12 hours stays in ED; we know from data there are inherent risks of harm to patients and as such it is an ICB expectation that trusts incident report.
- Concerns about the management of deteriorating patients- in ambulances, handover areas and escalation spaces
- Themes from incidents-
    - TES- treatment delays, privacy, and dignity, management of deterioration.
    - Lack of treatment in ED before transfer to wards
    - Ambulance delays impacting on risks to patients at home waiting for ambulances and whilst queuing to get into the ED department.
    - Significant capacity issues within departments (high volume of patients, high concentrated volume of ambulance activity at times).
    - Flow out of departments because of challenging discharge processes.
    - High acuity of patients.
    - IPC – Flu, norovirus.
    - Staffing – sickness, no availability of impact nurses, staff from other areas.
    - patients arriving on wards without a full assessment and treatment plan.

Themes have been shared in the weekly executive summary report of incidents and at the UEC network strategic board meeting. Further work is currently being undertaken to develop a summary of key themes and trends from incidents, through system meetings, and from implementing our assurance process, with a monthly report to share learning and support improvement.

To support the timely sharing of learning, the quality team currently share key issues on the daily system co-ordination call. In addition, through SCC, the Quality team led by the Director of Quality, are setting up weekly meetings, with patient safety leads/ specialists and executives in trusts to share learning, flag any issues and understand assurance around quality and safety in ED. The first meeting was on 20 January 2025.

Patient safety themes from RCN

The Royal College of Nursing published a report on the 16 January 2025, describing more than 5,000 nursing staff's experience of delivering care in urgent and emergency departments under significant pressures. These findings corelate with some of the concerns raised within the NENC system we have identified since implementing our process.

Issues raised nationally were: -

- 7 in 10 of the respondents said they'd delivered care in overcrowded and unsuitable places including corridors and converted cupboards.
- 9 in 10 felt patient safety was being compromised.
- Caring for large numbers of patients in corridors without always having the appropriate equipment.

Specific comments in Yorkshire and Humber including the North East were: -

- Not enough staff to care for patients.
- Delays in being seen and assessed, delays in treatment being commenced, making illness progression worse and longer stays in hospital.
- Patient safety not compromised but patient dignity severely compromised.
- Stressful environment for patients, family, and staff.
- Lack of call bells in corridors, delayed tests, and treatment.
- Unable to adhere to IPC guidelines and principles.

Recommendations / action required

The Board is asked to receive the report for information and discussion, and to note the assurances and the work being undertaken by the ICB specifically: -

- The actions taken to date to develop the ICB's approach to monitoring quality and safety within urgent and emergency care over the winter period.
- The next steps to develop mechanisms to share learning with trusts at the weekly meetings, with a purpose to share learning, flag any issues and understand assurance around quality and safety in ED.
- The ICB has implemented the process twice within December 2024, and are currently waiting assurance from the trusts.
- The process will go to Board to finalise in January 2025.

Name of Author: Sarah Dronsfield Director of Quality

Name of Sponsoring Director: Ann Fox, Interim Executive Chief Nurse
Neil O'Brien, Chief Medical Officer

Date: 20/01/2025