Lancashire Teaching Hospitals NHS Foundation Trust

Royal Preston Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Royal Preston Hospital

Inspected but not rated

A summary of CQC findings on urgent and emergency care services in Lancashire and South Cumbria.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Lancashire and South Cumbria below:

Lancashire and South Cumbria.

Provision of urgent and emergency care in Lancashire and South Cumbria was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff felt tired and continued to work under sustained pressure across health and social care. We found demand on urgent care services had increased. Whilst feedback on these services was mostly positive, we found patients were accessing these services instead of seeing their GP. Local stakeholders were aware that people were opting to attend urgent care services and were engaging with local communities to explore the reasons for this.

The NHS 111 service which covered the all of the North West area, including Lancashire and South Cumbria, were experiencing significant staffing challenges across the whole area. During the COVID-19 pandemic, the service had recruited people from the travel industry. As these staff members returned to their previous roles, turnover was high and recruitment was particularly challenging. Service leaders worked well with system partners to ensure the local Directory of Services was up to date and working effectively to signpost people to appropriate services. However, due to a combination of high demand and staffing issues people experienced significant delays in accessing the 111 service. Following initial assessment, and if further information or clinical advice was required, people would receive a call back by a clinician at the NHS 111 service or from the clinical assessment service, delivered by out-of-hours providers. The NHS 111 service would benefit from a wide range of clinicians to be available such as dental, GP and pharmacists to negate the need for onward referral to other service providers.
People who called 999 for an ambulance experienced significant delays.

Ambulance crews also experienced long handover delays at most Emergency Departments. Crews also found it challenging managing different handover arrangements. Some emergency departments in Lancashire and South Cumbria struggled to manage ambulance handover delays effectively which significantly impacted on the ambulance service's ability to manage the risk in the community. The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure.
We saw significant delays for people accessing care and treatment in emergency departments. Delays in triage and initial treatment put people at risk of harm. We

Our findings

visited mental health services delivered from the Emergency Department and found these to be well run and meeting people's needs. However, patients experienced delays in the Emergency Department as accessing mental health inpatient services remained a significant challenge. This often resulted in people being cared for in out of area placements.

We found discharge wasn't always planned from the point of admission which exacerbated in the poor patient flow seen across services. Discharge was also impacted on by capacity in social care services and the ability to meet people's needs in the community. We also found some patients were admitted from the Emergency Department because they couldn't get discharged back into their own home at night. Increased communication is needed between leaders in both health and social care, particularly during times of escalation when Local Authorities were not always engaged in action plans.

Royal Preston Hospital provided a full range of district general hospital services including an emergency department, critical care, general medicine including elderly care, general surgery, oral and maxillo-facial surgery, ear nose and throat surgery, anaesthetics, children's services, neonatal care, women's health and maternity, cardiac care, stroke care, cancer care, and care of the elderly. The urgent care service at this site was not provided by the trust

Additionally a range of general services are provided including ophthalmology**,** occupational therapy, pathology, physiotherapy, pharmacy, dietetics, outpatient services, diagnostic services, radiology and a range of specialist nursing services.

The hospital also provided several specialist regional services including for cancer, neurosurgery and neurology, renal, plastics and burns, rehabilitation, and was the major trauma centre for Lancashire and South Cumbria.

This inspection was focused on the emergency department and elements of the medical core service that included access and flow and patient experience.

Total attendances to the trust's urgent and emergency care departments had risen from 131,396 between December 2019 and November 2020 to 160,594 between December 2020 and November 2021. This was an increase of 22%. For the same time period children's attendances had risen from 24,831 to 34,702. This was an increase of 40%.

We spoke with staff of all grades including senior leaders, medical staff, nurses, domestics, practice educators, children's nurses and pharmacists.

We spoke with 16 patients and their relatives.

We reviewed nine patient records.

We attended a range of meetings including, bed management meetings, ward handover meetings and senior leadership interviews.

Urgent and emergency services

Requires Improvement 

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not always have enough nursing and medical staff to care for the number of patients that attended the department. The service was transferring to an electronic prescribing system, however; at the time of inspection, prescription charts were printed off with a risk of errors and oxygen was not always prescribed when administered. Staff did not always apply personal protective equipment, compliance with infection prevention and control training was below the trust target and audit results indicated a need for improvement.
- People could not access the service when they needed it and had to wait long periods for treatment due to high demand and lack of a capacity in the hospital.

However:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued by their managers. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, however compliance was below trust target for some modules.

Urgent and emergency services

Nursing and allied health professional (AHP) staff received and kept up-to-date with their mandatory training. As of March 2022, compliance for registered nurses, health care assistants (HCA) and AHP's was above the trust target of 90% for conflict resolution, equality, diversity and human rights, health, safety and welfare, moving and handling level two and preventing radicalisation (awareness). However, compliance for fire safety was 87.8%.

We were told that during the pandemic, delivery of face-to-face training had been affected due to social distancing requirements as well as staff sickness levels, and capacity issues. Training compliance was also affected by the national directive to stand down training due to the COVID-19 pandemic. The trust implemented an extension to completion of training in line with the guidance from Health Education England, which ended in October 2021. However, the directive to stand down training along with the pressures of the subsequent waves of the COVID-19 pandemic had continued to affect training delivery and compliance and inevitably led to recovery of training compliance taking longer than anticipated. A recovery plan was in place for the rest of 2022 to reach the organisational targets.

Basic life support training for adults and for children was part of mandatory training requirements. For nurses and allied health professionals, compliance was 90% for adults and 77.5% for children. For medical staff, compliance was 75% for adults and 59.3% for children. For health care assistants, compliance was 79.2% for adults and 77.8% for children.

Medical staff received and kept up-to-date with their mandatory training. As of March 2022, compliance for medical staff was above the trust target of 90% for conflict resolution, equality, diversity and human rights, health, safety and welfare, moving and handling level one and preventing radicalisation (basic awareness). However, compliance for preventing radicalisation (awareness) was 85.2% and fire safety was 69.5%.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The practice educator for the service monitored compliance with training updates and supported staff to complete. Training days were arranged so that staff were able to attend for face to face courses, any additional learning that was planned and also use time to complete any e-learning requirements.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training was part of mandatory requirements for staff with a target compliance of 90%. As of March 2022, for nurses, HCA's and AHP's, compliance for safeguarding adults level two was 94%, safeguarding adults level three was 97.4% and safeguarding children level three was 95.4%. For medical staff compliance for safeguarding adults level two was 90.9% and safeguarding children level two was 100%. However, safeguarding adults level three was 87.5% and safeguarding children level three was 81.3%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Urgent and emergency services

There were named safeguarding leads in the trust, that included a named doctor for safeguarding adults and children, named nurses for adults and children, a named midwife and the head of safeguarding. The trust also had a dedicated matron for mental health, learning disabilities, autism and dementia within the safeguarding team. There was a named consultant for safeguarding within the urgent and emergency service.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. In the six months prior to inspection, there were 45 incidents reported on the trust's electronic system. For adults, 90.3% were reported as low or no harm. The two incidents reported as severe harm and the one incident reported as moderate related either to community or another provider. For children, 92.8% were reported as low or no harm. The one incident reported as moderate harm was a community concern for a child who presented at the department.

The child safeguarding checklist was available electronically, as a mandatory field, at triage, for all children and young people who attended up to the age of 18 years old. There were safeguarding champions for young people aged 16 to 17 years old.

There was a mental health risk identification and management tool for all age groups at triage.

A child abduction simulation was undertaken, in November 2021, which highlighted what needed to be considered in a real event.

Cleanliness, infection control and hygiene

The service had adapted the environment to control infection risks. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

There were separate COVID-19 (red) and non COVID-19 (green) areas both for patients and staff.

Patients entered through a single point of access, known as the POD, where testing took place and symptoms were checked. Patients were then streamed through to one of two areas. For patients presenting with COVID-19 symptoms there was the COVID-19 assessment area for triage (CATS). For those patients with no COVID-19 symptoms they were streamed to the rapid assessment area for triage (RATS) if they arrived by ambulance or into the waiting room if they had arrived by own transport.

Streaming continued through the service into COVID-19 and non COVID-19 majors and resus areas.

The resus area for COVID-19 patients was located in a previous theatre complex with designated areas for donning and doffing of personal protective equipment (PPE); this provided enhanced air ventilation. Doors on cubicles were kept closed. There were single use 'ready tents' that were utilised for COVID-19 patients where they could be observed and staff protected.

For children, there was a dedicated entrance and two dedicated waiting areas; amber for children with any COVID-19 type symptoms and green for non-COVID-19. There were four side rooms that could be used for isolating patients within the paediatric area.

Urgent and emergency services

Staff completed mandatory training for infection prevention and control (level two). The trust target was 90%. For registered nurses, HCA's and AHP's the compliance rate was 88.4%. For medical staff, compliance was 66.1%.

Cleaning schedules were in place with all high touch surfaces and items cleaned multiple times a day. The domestic team were available to deep clean COVID-19 areas after each patient had left.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff did not always follow infection control principles that included the use of PPE. We observed that aprons were not always worn. The trust policy for the management of patients suspected as having COVID-19 indicated that staff working in an emergency department / acute assessment area (within two metres) should wear single use plastic aprons.

Patients were required to wear masks in the hospital; however, we observed this was not always adhered to including in the waiting room areas.

Matrons completed daily assurance checklists. Hand hygiene spot checks were included as part of these checklists. Between October 2020 and February 2022, there was 100% compliance with hand hygiene, except for December 2021 when compliance was 96%. Compliance with personal protective equipment (PPE) was between 82% and 100%, with an average compliance of 89.3%. For commodes, compliance was variable with an average of 94.3%. During March 2022, the sluice in the department was upgraded to allow for commode cleaning. The most recent audit by the infection prevention and control team was 87% in March 2022.

The trust's accreditation scheme included audits of a clean and tidy environment. The department was 100% compliant in all audits submitted between April 2020 and March 2022. This accreditation included IPC. There was a 100% compliance between February 2021 and December 2021. In January 2022, the audit question was reviewed to include management of waste and aseptic non-touch technique (ANTT). We were told the trust adopted a continuous improvement approach to audit. This meant that, on a six-monthly basis the audit questions changed to focus on areas identified as performing less effectively. The most recent audit results had dropped to between 70% and 80% compliance.

We were told that if there were shortfalls in the results from audits, an action plan was developed. IPC audits were reviewed at departmental level and also monitored at the divisional always safety first committee and the trust wide IPC Committee. The IPC team visited the department if needed and support was available from microbiology colleagues. We saw that learning was shared at staff meetings.

From the minutes of the emergency medicine division meeting, shared for March 2022, it was agreed that staff should wear protective eyewear in areas of high risk that included triage areas, however we did not see staff wearing eye protection during the inspection.

Water quality was monitored in the department. Between January 2021 and January 2022, there was 100% compliance with all monthly tests undertaken and 99.8% compliance between February 2022 and March 2022 .

The trust had identified that the conditions in the department, mainly due to the processes to manage COVID-19, could impact on control of IPC. This had been added to the divisional risk register with controls identified to help reduce the risk.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment.

The emergency department had increased its floor space in order to be able to have separate areas for COVID-19 positive patients and other patients. Departments close to the emergency department, that included a former day surgery unit, had been re-purposed to be able to see and treat patients safely.

This meant that there were two triage areas, two resuscitation areas and two majors areas. Each area had combinations of 'bay type' areas and isolation cubicles.

The trust had a zero tolerance to caring for patients in corridors. This meant that patients were cared for in private areas. Unfortunately, due to capacity issues patients, at times, needed to be examined in rooms not originally designed for patient care. These included the need to use the viewing room where families visited patients who had passed away temporarily.

All areas where patients were treated had access to oxygen and suction in the event of an emergency.

The children's area was adjacent to the service via a keypad entrance. At the time of inspection, the service had expanded and one door was awaiting the fitting of a locking mechanism. Staff were aware of the risk of children leaving the department and ensured they were accompanied. There was no dedicated resuscitation area for children, however there was additional child and baby resuscitation equipment available in the adult resuscitation area where children could be cared for.

There were plans proposed to improve the environment further to be more child-friendly in line with the Royal College of Paediatrics and Child Health's Facing the Future standards.

There was an incubator available, as well as birth packs, in case of an unplanned birth in the department prior to the involvement of maternity colleagues.

Staff carried out daily safety checks of specialist equipment. The trust's accreditation checks included audits of resuscitation equipment. Between April 2020 and March 2022, there was 100% compliance for the audits completed. There was no audits completed for August, September and October 2021.

Minor injury patients were treated in the co-located urgent care centre that was provided by another independent health service.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

There were challenges with capacity that meant there were delays in ambulance handovers. Between March 2021 and February 2022, handovers greater than 30 minutes ranged from 177 to 644 per month. For handovers greater than 60 minutes, for the same time period, there were between 13 and 293 delays per month.. At the time of inspection, the trust was working with the ambulance trust to try and reduce handover times. An additional escalation area had been identified as part of the collaboration project to reduce ambulance handover times.

Urgent and emergency services

Between January 2021 to December 2021, when arriving by ambulance, the time of arrival to initial assessment took longer than the England average, with performance deteriorating further from the average throughout the period.

As seen nationally, from January 2021 to January 2022 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. January 2022 saw 63% of turnaround times over 30 minutes, compared with 40% in January 2021. This meant that patients in the community requiring an ambulance could experience delays in accessing in a timely manner.

On arrival at the department patients were triaged (a process where patients are prioritised for medical need). The department monitored the time patients needed to wait for triage. In May 2021, the median time adult patients were waiting for triage was 10 minutes against a 15-minute standard. This figure varied between 10 minutes and 19 minutes between May 2021 and March 2022. This was similar for adult patients who presented with a mental health concern.

In January 2022, the median time patients waited in the department was 15 minutes from time to initial assessment compared with nine minutes in January 2021.

For children, median triage times varied from seven minutes in January 2021 to 22 minutes in November 2021. (There were three months where the time had exceeded the 15-minute national standard target with the standard met in nine months).

Due to high numbers attending the department, patients were experiencing long waits to be seen by a doctor. In May 2021, the median time for adults to be seen was 79 minutes. This had risen to 183 minutes in March 2022. For adults presenting with a mental health concern the average time had risen to about 219 minutes in March 2022. For children, the average time to be seen in May 2021 was 71 minutes. This had risen to 125 minutes in March 2022. For children presenting with a mental health concern the average time had risen to approximately 148 minutes in March 2022.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The critical care outreach team (CCOT) vital signs audit was completed quarterly. The eVital signs observation and fluid audit and the emergency observations and fluid balance audit were completed by individual areas of the medical division on a monthly basis. For the department's emergency observations and fluid balance audit there was 86.9% compliance between October 2021 and March 2022. The team reviewed data that related to patients who had arrived as emergencies to the department as well as for inpatients who had undergone sepsis screening and had received intravenous antibiotic treatment within one hour of diagnosis. Between October 2021 and December 2021, there was 79% compliance for patients in the department who had received a first dose of antibiotics within an hour. Between January 2022 and March 2022, this compliance was 69%. A number of actions had been identified that were either completed or on track at time of inspection. These included the development of a sepsis dashboard that was due to be completed by September 2022 and a digital escalation solution to alert deterioration of a patient.

Staff completed risk assessments for each patient on arrival, using recognised tools such as for reduced skin integrity, risk of falls and safeguarding.

Staff knew about and dealt with any specific risk issues including sepsis, VTE, falls and pressure ulcers. In the patient records we reviewed, we saw that staff had recognised possible sepsis and acted on it.

Urgent and emergency services

The service had 24-hour access to mental health liaison and specialist mental health support, both for adults and for children and young people. When a patient presented with a mental health concern staff from the department accessed a mental health grab pack. This was a tool to support staff to assess the risks that the patient presented to themselves and how to manage their care

Staff shared key information to keep patients safe when handing over their care to others.

A member of staff was allocated to monitor patients waiting in the waiting area and in ambulances. Ambulance crews escalated any concerns to staff so they could be seen.

All band five nurses were required to be trained in immediate life support (ILS) and paediatric immediate life support (PILS) as part of the first 12 months of their preceptorship. Band six and seven nurses completed advanced life support (ALS) and advanced paediatric life support (APLS).

As of March 2022, compliance with immediate life support for adults was 92.6% and for children was 55.8%.

The trust told us that each shift (a minimum of 16 hours/day) was led by a consultant who was ALS trained. Outside that time, there were senior clinical fellows/middle grade doctors, band six and band seven registered nurses who were ALS trained. There were no incidences within the six months prior to inspection where there was a lack of staff on shift without ALS training for any 24-hour period.

There was 75% compliance with ALS training and 64.8% compliance for APLS in the department against a target of 90%. This was an upward trajectory compliance rate following the recommencement of training during the COVID-19 pandemic.

In the department, there was one band seven and one band six children's nurse on shifts 24 hours a day. If there was no band seven or six children's nurse with APLS training, there was a band seven co-ordinator and consultants on shift who were trained. In the six months prior to inspection, we were told that there were no incidences where there was no staff without APLS training on a shift. There was 100% compliance for children's nurses, 72.7% compliance for band seven co-ordinators and 50% compliance for doctors.

The department also had access to request support from the children's assessment unit or the children's ward if needed.

There was no dedicated children's resuscitation area. If pre-alerted, an area in the adult resuscitation area was prepared by children's staff. There was children's emergency equipment available both in the main department and the children's area. There was 24/7 transfer helpline access for any child needing to be transferred to regional paediatric intensive care units.

A mental health calm room was in the main department for adult patients and a children's room was in the children's area. Neither rooms were ligature free. This meant patients were always escorted by staff or family members in these rooms. We were told that there was an assessment unit, in the hospital grounds that was part of the local mental health trust where there was a dedicated mental health suite, known as a Section 136 suite. There was also a S136 at the trust's other hospital location.

Urgent and emergency services

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The trust had increased the number of nursing staff. In November 2020 there were 1867, whereas there were 2063 in November 2021. This was an increase of 11%.

There had been three acuity reviews for the emergency department since the start of the COVID-19 pandemic. The reviews were undertaken by the leadership team for the department. These had resulted in a 76% increase in nurse staffing establishment for urgent and emergency care services. Escalation arrangements were under constant review throughout the COVID-19 pandemic. Safe capacity levels were established, and revised actions created and agreed through the senior operations group.

Managers used an acuity tool to calculate and review the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. However, due to the large numbers of patients attending the department it was not clear if the establishment was sufficient.

Staff worked 12 hourly shift patterns with seven day support from matrons.

Healthcare assistants were integrated into teams to support any reduction in the numbers of registered nurses.

Between April 2021 and March 2022, for adult registered nurses there was an average fill rate of 99.5% during the day and 94.9% at night. For adult unregistered staff there was an average fill rate of 86.1% during the day and 86.8% at night. The fill rates were calculated on 58 cubicles being occupied, acuity levels and on the average number of minor presentations. In addition, there were two band 7 co-ordinators on every shift. Patient numbers had been higher than expected in recent months. Unregistered fill rates had been over established between January 2022 and March 2022 to support the demands of the department. In paediatrics, between April 2021 and March 2022, for children's registered nurses there was an average fill rate of 95.6% during the day and 99.2% at night. For children's unregistered staff there was an average fill rate of 82.3% during the day and 73% at night.

Bank and agency staff were available on an unlimited basis and staff were requested who were familiar with the service.

An induction booklet was available for agency staff and there was a dedicated board where updates were shared with agency staff.

Managers made sure all bank and agency staff had a full induction and understood the service.

Safety huddles took place to share key messages.

The acuity tool had a red flag system that staff utilised at handover to raise any concerns such as, delayed pain relief, delayed intentional rounding or missed breaks for staff. We observed a nurse handover, in a designated room away from patients, and information was shared appropriately.

Nurse staffing levels were assessed and determined formally twice yearly that involved senior managers.

Children's registered nurses increased from two whole time equivalent (WTE) on a shift to three WTE shift in line with increased demand. There were 24 WTE staff for paediatrics.

Medical staffing

The service did not always have enough senior medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The trust had increased the medical staffing funded establishment numbers. In July 2019 there were 64.14 medical staff and advanced care practitioners. The funded establishment was 108.15 in March 2022 and had been increased in response to COVID-19. This was an increase of 69%. However, 12.24 of these posts were vacant at the time of the inspection. to the large numbers of patients attending the department it was not clear if the establishment was sufficient.

There were 76 whole time equivalent medical staff working in the urgent and emergency care services at the trust. Of these 30% were consultants (England average 29%), middle career was 11% (England average 15%), registrar group was 40% (England average 36%) and junior doctors were 19% (England average 20%).

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends. For children there were two children's emergency medicine consultants (PEM). We were told that a doctor was allocated to the children's area and PEM trainees were given the opportunity to work in the area.

Due to the numbers of patients in the department we were told consultants were working past their shift times. For evenings, shifts finished at 12 midnight however, we were told they could be there until about 4am to oversee any seriously ill patients.

Doctors we spoke with reported that the establishment targets were met. However, there were concerns that these numbers were based on numbers of patients prior to the pandemic and did not take into account the change in the layout of the department to separate COVID-19 and non COVID-19 patients.

Medical handovers were at 8am, 4pm and 11.30pm. There was no designated space for these to occur. The teaching room was available for medical handovers to take place. However during the inspection doctors told us there was no designated space for these to occur and therefore were not utilising the space.

The lack of ability to provide 24/7 trauma consultant cover was included on the risk register. Controls in place included the availability of an emergency department consultant within 30 minutes of a trauma call as well as other department consultants and a training programme for registrar colleagues.

Following the inspection, we received details about medical posts and vacancy rates for the emergency department. The department was funded for 26.7 whole time equivalent (WTE) consultants. However there were 16.2 contracted with a vacancy rate of 10.6. For registrars they were funded for 31.2. There were 25.8 contracted with a vacancy rate of 6.34 registrar grades. There were 44.8 contracted WTE junior doctors with a vacancy rate of 1.5. In addition, there were 9 WTE advanced care practitioners (ACP) to support medical staff.

Urgent and emergency services

Doctors submitted exception reports when workload changed. For January and February 2022, there were three exception reports for the emergency department; two were the reporting of three additional hours to shifts and one was the cancelling of teaching to be on call. All three were junior trainee doctors.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Records were a combination of paper and electronic. Paper records were stored securely where staff were always present.

Each area had a whiteboard to assist staff with required tasks. This included a patient's bed number, full name, presenting complaint, observation of vital signs, if an electrocardiogram (ECG) had been performed, any blood tests taken, pressure area care, COVID-19 swab, if a do not attempt cardio pulmonary resuscitation (DNACPR) was in place, any tasks needed and any other additional information. This meant that information about patients was visible to anyone in the department including relatives of patients.

Patient notes were comprehensive and all staff could access them easily. We reviewed five adult patient records and two children's records. All were completed appropriately.

When patients transferred to a new location, there were no delays in staff accessing their records.

The trust's accreditation scheme included records audits. Between May 2020 and March 2022 there was 100% compliance in monthly audits in the department.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines except for oxygen therapy.

The service had systems and processes in place to safely prescribe, administer and record medicines use, except for oxygen therapy. We found that when patients received oxygen (after any initial emergency response) it was not always prescribed or recorded as administered on the prescription chart.

The trust were aware of the poor oxygen prescribing and recording. It was included on the risk register. Following the inspection, senior staff we spoke with told us that daily audits of oxygen prescribing had been introduced and had resulted in 40% improvement in three days. A continuous improvement plan had been started to raise staff awareness of the need to prescribe oxygen. Staff were reminded of the importance of prescribing and recording administration of oxygen in the April edition of the trust's 'seven minute' bulletin.

The trust's medicine management policy followed best practice guidelines.

Staff stored and managed all medicines including those for emergency use safely.

Emergency drugs and equipment were checked regularly and all were in date. Trolleys were sealed.

Controlled drugs were managed safely. Staff monitored the temperature of the medicine fridges and rooms where medicines were being stored.

The pharmacy team were known and visible in the department. Staff knew how to contact them for advice or to obtain medicines outside the normal working day.

Medicines management assistants (MMAs) checked medicines stocks.

Pharmacists who worked in the department were non-medical prescribers.

However, we found that there were two types of record that were in use for prescribing and recording administration. A paper prescription chart was used on arrival to the department followed by an electronic chart (EPMA) once a patient was clerked in (admitted) by a doctor. (An Electronic Prescribing and Medicines Administration **(**EPMA) is a system where medicines are prescribed, administered and monitored electronically). The EPMA record was printed for department staff to use. This was a temporary 'work around' and had been included on the risk register. A new EPMA print out was required if any changes were made to a prescription.

We observed that one patient's name was only on the first page (and not on the following loose pages) of their medicine chart. We were told by senior staff that this issue had been fixed and couldn't happen again.

We also saw that another patient had two printed copies of the same chart, introducing the risk of medicines being administered twice.

The pharmacy team aimed to reconcile a patient's medicines when a decision was made to admit them to a bed and before clerking in.

There were plans ongoing in the trust to transfer the department to electronic records but, at the time of inspection, not all staff had received training related to the EPMA.

We saw that medicines incidents were shared at team meetings such as controlled drug documentation and oxygen storage. During the inspection we observed that all oxygen cylinders were secure and observed maintenance for wall brackets.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The trust had an electronic reporting system for incidents.

Staff raised concerns and reported incidents and near misses in line with the trust's policy.

The department had not reported any never events. Between June 2021and February 2022, there was an average of 237 incidents reported monthly. Of these an average of 232 were reported as either low or no harm.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Urgent and emergency services

Managers debriefed and supported staff after any serious incident.

The trust had a weekly cross-divisional meeting to review serious incidents and address any areas of emerging concerns called the safety and learning group.

Themes and trends and learning from incidents were reviewed in the department's speciality governance meeting with a chair's report into the divisional safety and quality committee.

Lessons learnt from incidents were shared in safety huddles, staff meetings and as part of learning and safety bulletins.

The trust monitored the number of falls in the department. Between October 2021 and March 2022, there was an average of 12 falls per month. A specific falls risk assessment and falls prevention interventions checklist had been implemented and falls mats and alarms had been purchased.

Champions for both falls and pressure ulcers had been appointed to share learning on a shift by shift basis and provide advice and support on interventions.

The trust identified a trend of an increasing in number of falls in the department. As a result, the department implemented the short stay falls risk assessment and yellow wrist bands for patients identified as a being at risk of falling.

The department monitored numbers of pressure ulcers. Between October 2021 and March 2022, the trust reported on average four pressure ulcers, each month, present on admission and a further four not present on admission to the department. Additional band two health care assistants were requested through the nurse bank to help with re-positioning and enhanced care. The department's safety checklist had been updated to include re-positioning. Replacement trolleys and mattresses had been purchased. Patients were transferred to hospital beds if a long stay was expected.

All incidences of patients attending for longer than 12 hours were investigated using a root cause analysis approach.

Mortality reviews included a medical examiner service review, primary mortality review, secondary mortality review and referral into the trust's serious investigation process if needed.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Urgent and emergency services

Policies were available on the trust's intranet for staff to access and the services guidelines were available on the trust's electronic record system.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

In the trust's clinical audit and effectiveness committee report to the quality committee, in November 2021, the trust's performance with compliance with the National Institute for Health and Care Excellence (NICE) guidelines was 93%. The trust had a dedicated NICE improvement programme to monitor compliance. For the medical division, of the 244 guidelines, 162 were fully compliant, 43 were partially compliant, one was not compliant and 38 were either in progress or outstanding.

We reviewed pathways for patients with suspected stroke, sepsis and deterioration and found that these followed national guidance with staff escalating appropriately. The trust provided a 24-hour thrombolysis service and had done for a number of years (Thrombolysis is the breakdown of blood clots formed in blood vessels, using medication.).

The service had a dashboard to monitor outcomes and had review processes in place such as mortality reviews, learning disability death reviews and the child death overview panel.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We reviewed records for a patient with a mental health concern and found they had been completed appropriately.

At handover meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

The trust's guideline for the malnutrition universal screening tool (MUST) for adults indicated that screening should take place within 24 hours of admission. (MUST is a screening tool used to detect patients who are at risk from malnutrition).This was not used in the department however, there were patients who had needed to wait for long periods in the department. This meant that nutritional needs may not be assessed in a timely manner.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Hot meals were available for patients when long waits occurred.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after it was identified they needed it or they requested it.

Urgent and emergency services

For the emergency department survey, in 2020, the trust scored similar to other trusts when patients were asked about pain control by staff.

An audit of pain relief was carried out between December 2021 and February 2022. Records of 20 patients were reviewed to assess if in line with the Royal College of Emergency Medicine (RCEM) Best Practice Guideline Management of Pain in Adults June 2021. Analgesia was recorded as offered in six out of 20 cases, including all of those reporting severe pain and all but one reporting moderate pain. However, there were some delays in administering.Staff had prescribed, administered and recorded pain relief accurately. An action plan was created to address the recommendations.

The children's department completed monthly pain and early warning score audits. Between March 2021 and March 2022, compliance was between 86.5% and 95.7%.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits with an assigned audit lead in the service.

Managers and staff used the results to improve patients' outcomes. Learning from audits was cascaded through audit meetings and speciality governance meetings.

Audits were monitored by the trust's clinical audit and effectiveness committee who reported their findings to the safety and quality committee twice yearly. The report in November 2021 included that compliance was monitored over a three year period because of the time intervals to publication of national and mandatory audits and to ensure that action plans completed reflected nationally determined publication dates.

The clinical audit and effectiveness department reported to the divisional safety and quality committee. The report in March 2022, indicated that all published audits had either action plans completed or in progress.

The trust had participated in 217 national mandatory audits between 2019-20, 2020-2021 and 2021-22 of which 130 (60%) reports had been published and of these 114 (88%) had action plans. The clinical audit department monitored action plans and supported clinicians with performance reported monthly in the governance dashboards as well as in reports for governance meetings and divisional safety and quality committees.

The trust presented an annual sepsis report to the safety and quality committee. In the report of May 2021 results were presented trustwide, by the sepsis nurse, for a number of indicators. For 2020 to 2021, there were between 80% and 90% of patients who had received antimicrobials within one hour of sepsis diagnosis in acute admission areas.

Improvement work focused on reducing the average time of 55 minutes between antibiotic prescription and administration. An intervention of a prescription tray was introduced which resulted in a reduction in the average time to administration of 29 minutes.

Other work included a trial where over a four week period, data was collected on 29 patients who were seen in triage. Of these 17 were identified as possible sepsis and the triage nurse could have administered antibiotics at that time. In all of these cases antibiotics were later prescribed by a doctor. The data indicated that the mean time to antibiotics from arrival in the department would have been reduced from five hours to one hour and 25 minutes if antibiotics had been administered at the point a healthcare professional had suspected sepsis.

On the basis of this data a patient group directive (PGD) for antibiotic administration was developed in conjunction with pharmacy and microbiology and had been approved by trust committees to implement. Training on the use of the PGD was due to start in March 2020 when the pandemic hit and had not occurred at the time of the sepsis report. We were not made aware of the programme during our inspection visit.

The trust monitored their outcomes of stroke services at both of the trust's hospitals. The trust participated in the Stroke-Sentinel Stroke Audit Programme (SSNAP). Between January 2021 and March 2021, for this location, the overall score was C. (Level E is the poorest level when assessed; grading is from A to E based on a number of indicators.). Between October 2021 and December 2021, the overall score was D. The areas that were the most challenged related to access to the stroke unit and therapy provisions.

The department monitored the number of patients who re attended within seven days. Between January 2019 and March 2022, there was an average of 7% of adults who reattended and an average of 3% for children.

We were told that due to intervals between completion and publication of national and mandatory audits, the most recent national audits for the Royal College of Emergency Medicine (RCEM) were published in March 2022. However; local trust results were not available at the time of inspection.

For the reporting period 2020/21, the trust had completed RCEM audits for infection prevention and control, pain in children and fractured neck of femur (thigh bone). At the time of the inspection the trust were submitting RCEM data of pain in children and infection, prevention and control for audits closing in October 2022.

The trust was in the process of re-auditing managing pain in adults according to RCEM guidelines 2022.

For the reporting period 2019/20, the trust had completed RCEM audits for care of the children in the emergency department, assessing cognitive impairment in older people in the emergency department and mental health in the emergency department.

For children in the department, actions and local audits had taken place to be compliant with the national standards.

For older people in the department, one action was in progress with all other actions completed.

For mental health in the department all actions had been completed.

The trust submitted to the Trauma Audit and Research Network (TARN). In the last report published, in 2020, the trust was above the national TARN target of 95%. Data was collected from adults and children for the TARN audits.

The trust completed structured judgement mortality reviews (SJR) as part of learning from deaths. The trust's minimum target per month was 20%. In January 2022, the emergency department reported 31 deaths, of which 20 were reviewed (65%). In February 2022, there were 14 reviews by the medical examiner of which seven were referred to the Coroner, 13 were rated unavoidable, and one had evidence of being avoidable; one case was scored 'adequate' for care, four were 'good' and nine were 'excellent'. Between October 2021 and December 2021, 58% of deaths in the department had an SJR completed.

The children's team monitored the service in line with the Royal College of Paediatrics and Child Health (RCPCH) facing the futures standards for paediatric care.

Urgent and emergency services

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through appraisals of their work. As of March 2022, compliance with appraisals for registered nurses and allied health professionals (AHP) was 69% and 50% for health care assistants against a target of 90%. However, compliance for medical staff had improved to 92%.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The trust was a teaching hospital for medical students.

The clinical educators supported the learning and development needs of staff. There was a training co-ordinator who was supported by two band six nurses who 'buddied' in the department.

Managers made sure staff received any specialist training for their role. Thrombolysis used in stroke treatment was delivered by stroke clinical nurse specialists.

Staff were required to complete competency assessments prior to undertaking specialist tasks dependent on their role. The induction checklist which staff completed included that staff were advised not to use any medical device in which they did not feel competent to use.

A sample of competency compliance was received from the trust. For telemetry, staff between bands three and band seven were required to complete training to be competent prior to using telemetry for patients. As of March 2022, compliance was 79.5% (97 out of 122). (Telemetry is the automatic recording and transmission of data from remote or inaccessible sources to an IT system in a different location for monitoring and analysis.)

For non-invasive therapy (NIV), band six and band seven staff were required to complete training to be competent prior to administering NIV at patients. As of March 2022, there was 58% compliance (18 out of 31). (Non-invasive ventilation is the use of breathing support administered through a face mask, nasal mask, or a helmet. Air, usually with added oxygen, is given through the mask under positive pressure.) There was a plan in place to achieve 90% compliance by the end of May 2022. We were told that staff had access to support from the band six nurse in charge of the respiratory high care unit (RHCU) and the band seven nurse in charge of the critical care unit (CRCU) as well as the consultant in charge of the emergency department and the medical registrar on call if needed.

For tracheostomy care, all band six and band seven staff in the department were required to complete advanced life support (ALS) training which included advanced emergency airway management including tracheostomy. There was 85% compliance for band six and band seven ALS training (27 out of 32). The department's consultants also had

emergency airway management skills meaning there was always a staff member on duty with the ability to maintain a patent tracheostomy. (A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe.) Patients with a tracheostomy were admitted to three designated speciality wards or the CRCU if needed. Staff also had access to support from other medical staff that included anaesthetists and ear nose and throat specialists that were available 24/7 if needed.

Simulation training sessions took place in the department as well as a designated training room with equipment available for training purposes.

Children's nurses had visited other specialist centres to learn from any good practice in other emergency departments.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The department has been working with the NHS ambulance service and attending governance meetings.There was a frailty consultant and multi-disciplinary frailty team who carried out daily in-reach into the department.

There was a mental health operational group meeting for adults, with attendance from external stakeholders. The frequent attender team, as part of the neighbouring NHS mental health and community trust supported vulnerable patients attending with mental health needs. The service also worked with the drug and alcohol team as well as the neighbouring independent urgent care centre, safeguarding and the tissue viability teams.

The children's team were supported by the children's division in the trust as well as the department. For mental health concerns the local child and adolescent mental health service (CAMHS) supported during the day with mental liaison team available overnight.

The department was supported by the trust specialist palliative care team seven days a week as well as the local hospice and community palliative care team. There were plans for the expansion of this service that included the hospice at home service.

A team of pharmacists supported the department with requirements related to monitoring of prescribing, administration and reconciliation.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

There was 24 hour cover of site managers and matrons. Discharge co-ordinators and the infection, prevention and control team had increased to seven day services.

Diagnostic services were available in the department that included x-ray and CT scan.

Thrombolysis, for stroke care was delivered 24 hours a day.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when attending the department and provided support for any individual needs to live a healthier lifestyle.

The department had health promotion information displayed on notice boards and in information leaflets. In the children's area, QR codes were displayed so that families could access a range of leaflets, in different formats, on their smart phones. At the time of inspection there was a focus on 'safe sleeping' with posters and a cot available to show parents.

There were leaflets for a range of conditions or injuries displayed near reception and the x-ray areas.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Urgent and emergency services

Assessment of MCA was included in assessment documentation at the time of admission for all patients. This required the completion of an MCA by a clinician on the electronic system following a patient's admission. All inpatient MCA and DoLS assessments were electronic. Compliance with MCA and DoLS was monitored by the safeguarding team.

The trust accreditation scheme included audit of MCA. Between April 2020 and March 2022, there was 100% compliance with mental capacity assessments in the department.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients we spoke with told us that staff treated them well and with kindness. We observed positive interactions between staff and patients.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with physical or mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The department had increased the footprint during the COVID-19 pandemic and utilised all available rooms or spaces to accommodate patients to maintain privacy and dignity. This meant that there were no patients being nursed on corridors.

Due to the high numbers of patients attending, escalation areas had been identified within and outside the department where patients could stay temporarily. However this meant there were occasions where patients, male and female, remained in a surge area for up to four hours. We saw privacy screens utilised in the department to separate male and female patients.

There had been a change and improvement to the trolleys in the department although patients were transferred to hospital beds if a long wait, in the department, was expected.

The department participated in the NHS friends and family test (FFT) to gain feedback from patients and those close to them about care and treatment. There was a separate child friendly feedback process. For adults between November 2021 and March 2022, the responses were on average 74.2% positive with on average 442 responses per month for the

department and an average response rate of 10%. For children between November 2021 and March 2022, the responses were on average 64.7% positive with on average 33 responses per month for the department and an average response rate of 4%. The department had recently introduced paper based response formats to increase the response rate. This had led to an increase in response by approximately 50%.

There was additional data presented for the medical division. This showed that the highest reason for negative feedback was waiting for treatment. When compared to other areas in the trust, the department had the lowest positive feedback scores.

For the CQC emergency department survey, in 2020, the trust scored similar to other trusts for all four themes of questions. These included getting help when needed, privacy during examination or treatment and treatment with respect and dignity.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. We observed staff supporting patients and those close to them.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The trust had a network of multi faith volunteers to support patients from a variety of cultural backgrounds that included Muslim, Sikh, Hindu, Bahal, Buddhist and Jain faith members and Christian (Catholic, Church of England, Methodist, Free Methodist, Baptist and Latter Day Saints).

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary. The trusts website included a number of options that included changing the language, font, download of an audible version, and changes to the font or text.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Urgent and emergency services

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service tried to plan and provide care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers strove to plan and organise services so they met the needs of the local population. The department was the main emergency department for the trust. There were limited emergency services, for adults only, between 8am and 8pm, at the trust's other hospital location.

The hospital was located close to the motorway network, for car drivers, and was on bus routes to other parts of the city. Car parking facilities had been reduced due to the Nightingale structure. This was a temporary marquee-type structure that was included two wards and facilities for patients in front of the main hospital.

There were automatic doors and disabled facilities for patients with mobility issues as well as changing areas for children and babies. There was also a dedicated changing place for anyone living with a disability and required a larger space.

The waiting areas included vending machines where snacks and drinks could be obtained whilst waiting.

There was a board indicating waiting times that was updated throughout the day.

There were collaborations between the ambulance trust and the hospital regarding reducing ambulance handover times and sourcing alternatives to emergency care for patients.

Facilities and premises were appropriate for the services being delivered for short periods. They had been increased to meet the demands of the COVID-19 pandemic. The department was not designed for patients attending for long periods of time, therefore wash facilities were limited.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients living with mental health problems, learning disabilities and dementia. The mental health liaison team was based in the department.

The neighbouring NHS mental health trust provided remote assessments with the NHS ambulance service to avoid patients attending the department unless essential.

There was a dedicated matron for mental health, learning disabilities, autism and dementia who provided support from the safeguarding team.

The service relieved pressure on other departments when they could treat patients in a day. There was a same day emergency care (SDEC) facility that was available from 8am until 8pm daily although the last patient was accepted at 5pm. We were told requests have been submitted to open 24 hours a day.

Urgent and emergency services

Staff knew about and understood the standards for mixed sex accommodation, that included recommendations for surge beds, and knew when to report a potential breach.

For children and young people there was a dedicated entrance, area for triage, treatment and waiting rooms, separate from the adult areas.

Children's areas included child appropriate décor, posters and information boards including pictures of the nurses. There were distraction toys that could be given to children and other toys such as colouring books and crayons for siblings. General toys and films to watch were available, although reduced due to COVID-19 infection, prevention and control restrictions.

The service had systems to help care for patients in need of additional support or specialist intervention. However, the department experienced challenges with regards to discharges. This included discharges in the evening or night. The trust's experience was that many care homes were reluctant to accept patients back to their normal place of residence after a designated time of day and at weekends. This meant patients were remaining in the department, longer than was required, or required an overnight bed. System partners had shared that there was limited availability of beds for patients identified as elderly mentally infirm (EMI). The trust had also raised concerns regarding 'crisis' hours. These were extra hours of support that were allocated by the local authority. The trust found that when the hours were made available, they were taken within a couple of hours of release by other healthcare providers locally.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

There was a 'flagging' system on the electronic system to indicate patients in need of a reasonable adjustment.

Visiting was restricted to families of patients with a care need such as dementia, end of life, a learning disability, autism and communication difficulties.

Staff understood and applied the policy on meeting the information and communication needs of patients living with a disability or sensory loss. Easy read information was available via the trust's intranet.

The department had information leaflets available in languages spoken by the patients and local community both for adults and children.

Managers made sure staff, and patients, loved ones, and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

A mental health calm room was in the main department for adult patients and a children's room was in the children's area. In the adult area the room had been decorated with a beach scene. There were plans to improve the environment of the children's room.

A 'safe space' pathway had been developed across the integrated care system, by the local mental health trust for children and young people. This included a flow chart to signpost to services over a 24-hour period that could be phone and/or face to face consultations dependent on triage and assessment.

In the children's area there was a Makaton display board with 'sign of the week'. A staff member had produced some visual aids to support children with communication issues. Going forward there was a plan for more aids in other formats such as for visually impaired children. There was no dedicated play specialist in the department however, staff could request support from the childrens ward during weekdays. Health care assistants were employed in the department and could support with distraction techniques.

There was ongoing work and clear plans to improve services further for children who presented with complex needs in collaboration with in-patient and community colleagues.

Access and flow

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

Between March 2021 and March 2022, attendance for adults at the department had been between approximately 3,585 to 4,613 patients per month. For children, in the same time period, there was between 574 and 1,016 patients per month.

Managers monitored waiting times and made sure patients could access emergency services when needed, however not all patients received treatment within agreed timeframes and national standards. There were four patient flow meetings daily and seven-day matron cover in the department.

The service moved patients only when there was a clear medical reason or in their best interest. At the time of inspection, we observed that overnight 34 patients were transferred out of the department. In addition, an escalation area had been re-opened to help create bed capacity in the department for acutely ill patients. .

Since January 2022, the trust had increased bed numbers, by 50 patients with the construction of a temporary Nightingale facility. This was used for patients who were ready for discharge or medically stable and had a discharge plan in place. We were told that this will be decommissioned in June 2022. A modular build has been created at the neighbouring hospital and additional beds were being sourced in the community.

There were patients identified who were triaged and sent directly to areas outside the main department to help streamline and deliver timely care pathways. This included children who went either to the children's area or went to the children's assessment unit on the children's ward. There was same day emergency care (SDEC) areas where patients could be seen directly. This meant patients could be assessed, diagnosed, treated and discharged home the same day, rather than being admitted. The frailty unit worked in collaboration with the NHS ambulance trust to help prevent unnecessary hospital admissions and re admissions. Alternatively, there was daily in-reach from the frailty consultant to identify any patients who may meet the criteria.

Urgent and emergency services

Between March 2021 and February 2022, the four hour standard to see, treat, discharge or admit patients in the department was between 75% and 80% against a target of 95%.

Speciality doctors reviewed patients in a timely way, however capacity issues on wards meant patients needed to wait for long periods in the department until a bed came available.

Consultants completed board rounds to prioritise care and have oversight of all patients.

On the first of the two day onsite inspection, at 9.30pm we observed 101 patients in the department, of which 53 were awaiting a bed on a ward. We observed that patients who experienced a delay in moving to a ward were provided with a hospital bed and care needs attended to. Patients, in the waiting room, were expecting routine waits of over five hours and there were ambulances waiting. The following morning 34 patients had moved out of the department. An identified escalation area had been re-opened to help create space in the ED. The longest stay, at that time was 61 hours for a patient who required a side room.

The Royal College of Emergency Medicine recommends that the median 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 over the 12-month period from January 2021 to December 2021.

During the pandemic period, the trust did meet the standard from January to April 2021 when median time to treatment was around 50 minutes. In the most recent month for published data, December 2021, the median time to treatment was 70 minutes compared to the England average of 65 minutes. During 2021, the time to treatment peaked at 83 minutes in October.

Performance for all types of emergency department attendances, at the trust was worse than the England average, for the period of February 2021 to May 2021 for achieving the four hour standard: there were 79% of patients who had spent less than four hours in the emergency department. National performance then deteriorated at a faster rate than at the trust. Between June 2021 to January 2022, the trust performance was 75% to 80% and slightly better than the England average.

From December 2021 to March 2022, the department's performance had been generally worse than the regional and England average for waiting more than four hours from the decision to admit until being admitted; between February 2021 and January 2022 the trust's monthly percentage of patients was around 30% which was worse than the England average and showed a deterioration overall.

The department monitored patients who had waited longer than 12 hours on a trolley. There were no children reported to have waited longer than 12 hours. In February 2022 the trust was much worse than other trusts for patients spending over 12 hours from decision to admit (DTA) until admission to the hospital. For adults, between March 2021 and March 2022, there was an average of 85 patients per month. The number varied from 50 to 130 per month.

Over the 12 months from February 2021 to January 2022, 722 patients waited more than 12 hours from the decision to admit until being admitted. These occurred in every month, though were lowest in February 2021, when seven people waited longer than 12 hours to be admitted following decision.

In December 2021, the trust's monthly median total time in the emergency department for all patients was 166 minutes compared to the England average of 167 minutes.

Urgent and emergency services

The trust reported the average time that patients spent in the department after a decision to admit had been made by a clinician. Between March 2021 and March 2022, the time had increased from an average of 300 minutes (five hours) to 900 minutes (15 hours). This was similar for adults who presented with a mental health concern. For the same time period, children waited an average of 50 to 100 minutes. For children presenting with a mental health condition, the average waiting time had increased to about 300 minutes (five hours) in October 2021 however, this had reduced to about 100 minutes in March 2022.

From February 2021 to January 2022, the trust's monthly average total time in the emergency department for all patients was in line with the England average.

Between March 2021 and March 2022, the number of patients who left the department without being treated had risen, for adults, from an average of 2% to 9%. For adult patients presenting with a mental health condition there was an increase up to about 12%. For the same time period, there was an average of 3% of children who had left without being treated. For children presenting with a mental health concern, there had been a rise up to about 5% in November 2021 however, the number had reduced to zero in March 2022.

The department monitored the number of patients who had reattended within seven days. Between January 2019 and March 2022, there was an average of 7% of adults who had reattended and an average of 3% for children.

The impact of exit block on patient safety was included in the divisional risk register that was reviewed monthly. Exit block is when patients in an emergency department who require admission to the hospital are unable to be moved to a bed on a ward because of a lack of availability.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. The board in the waiting area included information about how to provide feedback.

Staff understood the policy on complaints and knew how to handle them. Between October 2021 and March 2022, there were a total of 38 complaints. Of these two were upheld, nine were not upheld and 12 were partly upheld. There were 16 that were ongoing with no outcome at the time of inspection. There were no complaints that had been referred to the Parliamentary and Health Service Ombudsman (PHSO).

Top themes from complaints and concerns were communication, waiting times for assessment and investigations and admission/transfer and discharge.

The trust shared copies of complaint responses for our review. The trust had responded in a timely way and the tone was apologetic and sympathetic for the patients' poor experience of care and provided responses to patient questions.

An audit of complaint responses was carried out in 2021. The audit concluded that complaint responses were generally appropriately written with clear identification of learning.

Urgent and emergency services

We were told that lessons learnt were discussed in monthly governance meetings and cascaded throughout the department via staff meetings and bulletins that included changes to practice.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The department and division had stable leadership. The emergency department was part of the medical care division.

Leaders were visible in the department with seven day matron cover. Shift leaders were visible wearing red uniforms; both medical and nursing leads.

Executive leaders were available to support staff in the department and were well cited on any concerns. At the time of inspection, we saw leaders of all grades in the department. Leaders encouraged staff and provided opportunities to develop their skills.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The medical division followed the clinical strategy that was trustwide.

The trust launched their Always Safety First strategy in 2021. This included the trust's aim to provide excellent care by being caring and compassionate, recognising individuality, seeking to improve, building team spirit and taking personal responsibility.

The division's clinical strategy, launched in March 2022, had a three-year vision:

"To return to a position of being an exemplar of good practice across the full range of acute and planned care in our secondary and tertiary services, by enabling our staff to first meet and then exceeding national and local targets, in line with the Trust mission to provide excellent care with compassion."

The urgent and emergency care vision was that "patients will receive the right pathway first time from prehospital to in hospital through dynamic patient flow. The emergency department will treat the trauma and acutely sick, save lives through timely patient-centred emergency care driven by educational innovation, high performing teams and practice-changing research."

A display board in the department included the trust's strategic aims, corporate goals and departmental goals.

Urgent and emergency services

The trust's plans, for the future over a number of years was, to achieve and maintain this vision included the new hospital programme that would incorporate an emergency village, digital services for virtual and 111 appointments, the workforce, the always safety first strategy and continuous improvement with weekly meetings with colleagues including the ambulance provider.

Culture

Staff felt respected, supported and valued by their managers. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

During the onsite inspection we observed staff working together well as a team to support patients. Staff worked hard to care for patients and were encouraged to speak up about any concerns.

The trust's equality, diversity and inclusion (EDI) strategy included principles that underpinned it. These were: demonstrating collective commitment to EDI, being evidence led and transparent, recognising the importance of lived experience, being representative of their community and, bringing about change through education and development.

Doctors told us that they were well supported by consultants despite low morale due to the numbers of patients and lack of available space to conduct consultations. There were occasions when they had needed to stay longer than their scheduled hours and did not always get allocated breaks. There were difficulties transferring patients out of the department, due to a lack of available beds in the hospital. This was despite triaging, streaming and escalating concerns.

Doctors reported a cohesive team and felt appreciated by the senior consultants. Junior doctors and nurses worked well together to do the best they could for patients but told us they felt frustrated that frail and elderly patients waited long periods to be seen.

From the staff survey results of 2021, the trust compared in line with other trusts. For the medical division, the division scored worse when compared to other divisions in the hospital. The nursing division scored better than other workforce groups within the trust.

Governance

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

Bed meetings were held daily to monitor the numbers of patients in the trust; specific patients were highlighted, such as with a mental health need, and ways to transfer patients safely were discussed to support the ambulance trust and use escalation areas if necessary. Other hospitals in the integrated care system were discussed to compare capacity and review if any patients were for repatriation to their local trust.

Daily gold command meetings and joint cell meetings were held, across the integrated care system, where capacity and any concerns were discussed for each trust so that support could be offered if possible.

Infection prevention and control (IPC) audit results were included in matrons' assurance reports that were shared at the department's safety and quality meetings and monthly staff meetings.

They also presented at the divisional always safety first meeting as part of the IPC report and shared at the trust IPC committee.

The department had a high number of incidents reported with low levels of serious harm which demonstrated a positive incident reporting culture.

Robust governance arrangements were in place to ensure lessons learnt with learning shared in safety huddles, staff meeting and as part of learning and safety bulletins.

Themes and trends from incidents were reviewed at specialty governance meeting with a chair's report to the divisional safety and quality committee with representation from the emergency department.

Moderate and above incidents were reviewed weekly at the trustwide safety and learning group.

Any learning from incidents informed the always safety first working groups.

Learning from completed serious incident investigations were shared with the trust safety and quality committee.

The trust had meetings with other trusts including the ambulance and mental health providers as well as the independent health provider for the urgent care centre. They were working with the ambulance trust to improve the handover times of patients as a result of limited capacity in the department.

Joint standard operating procedures (SOP's) were in place with external providers to minimise delays and use possible admission voidance pathways.

Governance meetings were in place to review incidents including weekly departmental improvement forums with the divisional triumvirate and monthly departmental safety forums with the executive team as well as case review meetings.

Monthly divisional meetings, for the trust's always safety first campaign, were planned with attendees invited from a wide range of multi-disciplinary areas. These included ward matrons and managers, practice educators, estates manager, pharmacists, specialist nurses, including tissue viability, infection prevention and control, domestic services, sepsis leads, outreach team and clerical support. Representatives were invited from the emergency department. Only a sample of those invited were present at the meetings we reviewed the minutes for**.**

The medicine division scheduled monthly board committee meetings. This was attended by senior managers and clinical directors, from the division that included the emergency department clinical director. However, the department's clinical director was not present at all meetings shared.

Emergency medicine divisional meetings were held monthly. There was varied attendance despite the list of staff invited. No information was included about the roles of staff that were invited. Updates were shared regarding a range of items such as medicines, staffing, matters arising, performance, audit, safeguarding and complaints.

Clinical governance meetings were held for the emergency department. Agenda items included risks, incidents, patient experience and items for positive and negative escalation.

There was a weekly strategic operational group that took place to discuss any issues.

If needed, further internal actions were enacted through the chief executive to help reduce the numbers of patients who were waiting both in ambulances and in the department.

There were monthly joint paediatric emergency group (JPEG) meetings which included multi-disciplinary representatives from the department and children's services to help promote and embed partnership working. The group reviewed clinical issues, SOPs, guidelines and streamline care pathways.

There were monthly meetings between the children's matron and departmental matron to jointly review any incident reports.

There was an annual review of the Royal College of Paediatric and Child Health (RCPCH) Facing the Future Emergency Care standards.

The trust's accreditation scheme included the department for routine assurance checks.

At a system level the urgent care delivery board was chaired by the chief executive.

We were told that the trust had participated in 217 national mandatory audits between 2019-20, 2020-2021and 2021-22 of which 130 (60%) reports had been published and of these 114 (88%) had action plans. The clinical audit department supported clinicians with monthly reporting onto the governance dashboards as well as in reports for speciality governance meetings and divisional safety and quality committees.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The department and division recorded all their risks on the risk register. Governance meetings were held monthly where risks were reviewed and discussed. Items for escalation were reported into monthly divisional governance meetings via a chair's reports.

Any operational risks that were scored as high (a risk score of 15 to 25), were maintained on the divisional risk registers and escalated by the divisional boards alongside any high scoring corporate operational risks to the monthly executive management group and then to the board via committees of the board. Risks were discussed at the department's clinical governance meetings.

At the time of inspection there were 18 risks on the risk register that included scores with controls in place as well as any gaps noted. These were reviewed monthly.

The trust had developed their bed escalation and surge plan. It was used alongside the operational pressures escalation level (OPEL) actions cards to ensure all actions, in addition to the escalation of beds, was taking place as appropriate across all areas. (OPEL is a method used by the NHS to measure the stress, demand and pressure a hospital is under.)

The plan set out the criteria for enacting this business continuity that included no in-patient and escalation beds available, long waits in the department and limited space in the department. The temporary Nightingale surge hospital was being utilised as part of the escalation process.

Urgent and emergency services

The trust had produced a standard operating procedure for patients who experienced a long wait, more than 12 hours in the department, to help with keeping patients safe and mitigate any risks. This included internal guidance as well as the integrated system guidance however, the flow chart only included patients in the trolley areas (majors and resus) and did not including waiting areas where ambulatory patients could be waiting to be seen.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff completed mandatory training for information governance with a target of 95%. As of March 2022, compliance for nurses, health care assistants and allied health professionals was 92.7%. For medical staff compliance was 84.8%.

The trust had transferred to an electronic system for the management of medicines. The electronic prescribing and medicines administration **(**EPMA) system had been implemented in stages across the trust. It was in place in the emergency department. However, at the time of inspection staff had not all completed training so they were still using paper records as well. The trust had identified risks with two processes running concurrently and were monitoring the 'work arounds'.

The trust used dashboards to monitor performance. They were working with system partners to address concerns highlighted that included exit block and capacity. Exit block is when patients in an emergency department who require admission to the hospital are unable to be moved to a bed on a ward because of a lack of availability.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Trust wide, key messages were cascaded via the weekly chief executive newsletter. Seven minute briefings were sent to remind staff of key issues as well as executive question and answer sessions for staff.

There was a weekly meeting led by the director of nursing, midwifery and allied health professionals.

There were monthly team meetings scheduled. This had taken place in the three months prior to inspection, although we noted December 2021 had been stood down for operational reasons. Attendance was limited to between eight and ten staff. The minutes shared from March 2022 included names and grades of nursing staff that showed a mix of registered, unregistered and students.

A range of agenda items were discussed including document completion, medicines safety, incidents, infection prevention and control, training opportunities, accreditation audits and feedback and notes security. Lessons learned was a set agenda item, however these were not discussed in the minutes shared.

A display board was in the department where staff could make suggestions or contribute ideas. Other boards included governance information/performance data and advice for staff. Boards in children's area were designed in a child-friendly way for staff and families. In the children's area there was a board dedicated for students that was child friendly.

A dedicated well-being room was available in the department where staff could visit for one to one or group sessions.

The trust had introduced a range of support for staff during the pandemic such as a psychological wellbeing helpline, a range of psychological therapies, including counselling and cognitive behavioural therapy, occupational health, Schwarz rounds (group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare), mindfulness programmes, group therapy, freedom to speak up, mental health drop-ins and an employee assistance programme available.

Social media and the trust website were available for sharing information such as visiting guidelines.

For children there was a youth forum. This was made up of a group of young people who volunteered to work alongside leaders from the children's services to improve the experience for children and young people at the trust. Prior to the COVID-19 pandemic they visited the children's area to review facilities and offer feedback using a 15 step method. A video was produced, on social media, for children and young people to access. This showed footage of the group's visit to the trust.

The youth forum had not been able to visit on site during the pandemic however there were plans to re-introduce these meetings in the upcoming months.

A local parent support group provided 20 "crisis bags" that contained essential toiletries for parents staying in hospital. Going forward they have offered to participate in focus groups and to be involved in future work relating to children's mental health.

As part of the trust's always safety first campaign, a pilot scheme of live feedback took place in February 2022. Members of the patient experience team and the patient advice and liaison service (PALS) attended wards across the organisation to speak with patients. They spoke with 383 patients with 362 patients who reported they felt safe. The data was trustwide and going forward real time feedback was being included in the patient experience strategy.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The department had a plan on a page that included system partners included in workstreams. These included supporting 111/999, emergency department flows, improving hospital flow and discharge services, ambulance trust see and treat / hear and treat, children's and young people's services, digital/technical, workforce.

There was an acknowledgement from senior leaders that staff had worked hard following unprecedented conditions, finding innovative ways to care and treat patients. This had included the application of non-invasive ventilation therapy at the start of the COVID-19 pandemic.

The trust had invested in a point of care system for early detection of gastrointestinal infections. This was being piloted in the department. We were told that the result of the specimen analysis determined if the patient needed to be nursed in a side room. This was part of monitoring infections such as norovirus.

The trust's continuous improvement strategy was focused on the development of leadership and the culture providing opportunities for improvement and the celebration of successes. The research and innovation strategy had been embedded, within the trust, for a number of years and continued through the pandemic.

Urgent and emergency services

Areas for improvement

MUSTS

Urgent & Emergency Services

- The service must ensure that nurse staffing levels, are safe for the numbers of patients in the department. (Regulation 18 (1)).
- The service must ensure that medical staffing levels, with the right qualifications and competencies, are safe for the numbers of patients in the department. (Regulation 18 (1)).
- The service must ensure that all staff complete mandatory training requirement including resuscitation, infection prevention and control and safeguarding. (Regulation 18 (1)(2)(a)).
- The service must ensure staff adhere to guidance regarding infection, prevention and control. (Regulation 12 (1)(2)(h)).
- The service must ensure that oxygen therapy is prescribed as per national safety alert and a record of its administration maintained. (Regulation 12 (1)(2)(g))
- The service must ensure that all staff receive an annual appraisal. (Regulation 18(1)(2)(a)).

SHOULDS

Urgent & Emergency Services

- The service should ensure that all doors leading to the children's area are secure. (Regulation 12).
- The service should ensure that all patients with mental health problems are observed appropriately as no dedicated suite in the department. (Regulation 12).
- The service should ensure that staff complete checks of canula sites if prolonged stay in the department. (Regulation 12).
- The service should ensure that patient identifiable details are kept confidential when displayed on public boards. (Regulation 17).
- The service should ensure effective processes to improve audit results including infection, prevention and control and sepsis. (Regulation 17).
- The service should consider assessment of malnutrition due to potential long waits.
- The service should consider revising the standard operating procedure for long waits to include ambulatory patients.

Medical care (including older people's care)

Inspected but not rated

We did not rate this service

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to useful information. Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- The frailty unit virtual ward supported many patients discharged home to reduce readmittance through early interventions and liaison with community services.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always have enough medical and nursing staff to care for patients and keep them safe. Due to national shortages of nursing and support staff not all wards had a full complement of nursing staff. There was a reliance on the use of bank and agency staff.
- We found that when patients received oxygen (after any initial emergency response) it was not always prescribed or recorded as administered on the prescription chart.
- Not all parts of the service facilities met the needs of patients. The lack of shower facilities on the acute frailty assessment unit and the lack of natural sunlight on the Nightingale hub did not provide an excellent patient experience.
- The therapy team on the acute frailty assessment unit were not available over a weekend to support existing frailty patients with their therapy needs.
- Bed pressures within medical services meant that at times patients were not always being provided care and treatment on the correct medical speciality ward.
- There were patients ready to leave hospital who were medically optimised but unable to leave, due to shortages of community services. This created further access and flow problems throughout the trust.
- Not all strategies introduced by the trust to address the significant access and flow issues across medical wards were utilised effectively.

Medical care (including older people's care)

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

All ward areas visited were visibly clean and had suitable furnishings which were clean and well-maintained. Patients we spoke with reported they felt the wards were clean.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The wards displayed cleanliness audit data to inform patients and their family of the results from their internal cleanliness audits

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore the correct PPE including surgical face masks in accordance with national guidance. All clinical staff were bare below the elbow to enable effective cleaning of their hands. Patients told us, and we observed, how staff cleaned their hands regularly.

Staff screened patients for COVID-19 throughout their admission. Patients told us they were regularly tested for COVID-19 whist receiving care and treatment at the trust.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Patients experiencing COVID-19 symptoms or were known to be COVID-19 positive were cared for in single rooms. We found on wards that single occupancy rooms were saved for isolating patients with COVID-19 symptoms.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The service did not have suitable facilities to meet all needs of patients. Patients and staff told us the lack of day light on the Nightingale hub could make them feel disoriented as they could not use the daylight to help judge time. Staff reported the lack of ventilation on the Nightingale also made the environment hot. The trust advised there was heating, cooling and ventilation, controlled by a building management system (BMS) that kept the environment to comfort conditions and relevant air changes. No explanation was provided by the trust that despite the building management system staff still reported that the environment was hot. We also observed and staff told us there was a lack of privacy for patients on the Nightingale hub as it was very open, so conversations could be overheard. Toilets and bathrooms were accessed by a ramp and were not closely situated to the bays.

Staff carried out daily safety checks of specialist equipment. However, we found that on the cardiac catheter suite which was also used as a surge ward there was catheter care equipment with an overdue service date from August 2020.

Medical care (including older people's care)

At the time of our inspection the cardiac catheter suite as providing care to male and female patients in separate bays. We were informed at times of high bed demand that it was not always possible to provide non mixed sex beds or toilet facilities.

There were no patient showering facilities on the acute frailty assessment unit. We were told that patient length of stay on the ward was usually within 72 hours. The admission protocol for the unit stated that admission should be less than 48 hours. However, this did not negate the need for frail elderly patients who were acutely unwell needing showering facilities.

The service had enough suitable equipment to help them safely care for patients. Staff did not report there was a shortage of equipment.

Patients could reach call bells and staff responded quickly when called. We observed call bells to be accessible to patients. Patients we spoke with confirmed they could summon help if they needed to.

Staff carried out daily safety checks of specialist equipment. Wards we visited had emergency

resuscitation trolleys available. These were locked and secure with tamper seals. The checks we reviewed were found to be completed daily with the name of the staff member, date and their signature.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. This included tools to record vital observations for patients and early warning scores were used to identify patients at risk of deterioration. Staff informed us they had access to a critical outreach team 24 hours per day should a patient suddenly require emergency intervention.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed four patient records and saw that risk assessments were completed on admission and reviewed regularly, including when a change occurred. Risk assessments were recorded on an electronic system and in paper records stored in locked cabinets.

Staff knew about and dealt with any specific risk issues. Staff showed us additional assessments that would be made for patients if a risk was identified and told us of the action, they would take to manage the risk. For example, should a patient score highly (score 5-6) on a frailty assessment then this would trigger for a referral to the community frailty nursing team to follow up.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health.

Staff shared key information to keep patients safe when handing over their care to others. Key information was kept electronically and in paper format. Staff were clear of how to refer to other agencies to support the patient's journey through the hospital. For example, a patient referred to the mental health liaison team would usually be seen within 24 hours.

Shift changes and handovers included all necessary key information to keep patients safe. However, on the acute frailty assessment unit we saw that on a shift handover staff arrived throughout the handover potentially missing key information relating to care needs.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Due to national shortages and sickness rates of nursing and support staff the service did not always have enough permanent nursing and support staff to keep patients safe. Managers of the service told us they had to use bank and agency staff to support the acuity of the patients across the medical wards. In some areas the staffing establishment had been reached. For example, on MAU (medical assessment unit) the ward had recruited enough registered and non-registered nursing staff. However, due to shortages across other medical wards these staff were often deployed to work away from the ward.

Data from the trust indicated planned rotas for registered and unregistered staff from May 2021 to April 2022 was below 85% for day and night shifts. The exception to this was for unregistered staff on night shifts which was on average 96%. We reviewed five wards and the discharge lounge as part of our inspection and found planned versus actual staffing levels were appropriate. Healthcare assistants were integrated into teams to support any reduction in the numbers of registered nurses.

The ward manager could adjust staffing levels daily according to the needs of patients. Staff told us that often when they had a full rota of staff, they would need to support other areas of the hospital that was understaffed which left their own ward short.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers used an acuity tool to assess the numbers of staff required to safely care for patients.

The medical care wards often had to use bank and agency staff to fill shifts. Some of these were staff who were familiar with the wards, but not always. Staff reported that long standing vacancies were block booked with bank or agency staff. This helped to ensure continuity on the ward and ensured staff availability.

The trust was recruiting international healthcare professionals to reduce vacancies within services. There were processes in place to support healthcare professionals move to the UK both pastorally and clinically. The trust did not seek reimbursement of any costs should internationally recruited healthcare professionals decide to return home or transfer to another organisation.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Information provided showed that from March 2021 to February 2022 posts filled against substantive establishment for junior doctors had declined from 90% to 78%, Senior and consultant posts had remained around 80%. The trust has 18 job offers in the pipeline for the medicine division, but the highest number of vacancies were in the medical assessment unit.Doctors worked additional hours across several rotas to fill shifts .

Medical care (including older people's care)

Sickness rates for medical and dental staff varied across medical specialties. Senior leaders monitored the sickness rates. The risk register reflected that there had been gaps in the registrar rota for medical staffing which could compromise patient safety. Controls were in place to support the shortfall and reviewed monthly by senior leaders.

Turnover rates for the trust were below the sector average at 10.2%. The sector average was 28.6%. (Turnover rate is calculated as a sum of leavers in full time equivalent divided by an average of staff in full time equivalent).

The recruitment of International Medical Graduates (IMGs) formed part of the trust's Medical Recruitment and Retention Strategy. A relationship manager role was developed to support international medical graduates who reported feeling supported prior to, during and immediately after their arrival in the UK. This enabled them to be able to start their clinical work sooner and in some cases within a week of arriving in the UK.

Medicines

Staff followed systems and processes to prescribe and administer medicines safely. The service used an electronic system to prescribe and record administration of medicines. However, when patients were administered oxygen, this was not always prescribed, or administration recorded.

Staff reviewed patients' medicines regularly and provided advice to patients and carers about their medicines. The pharmacy team were present on the medical wards during the day between Monday and Friday to facilitate medicines ordering and provide clinical support. Staff could contact the team at all other times.

Staff completed medicines records accurately and kept them up to date. Patients' allergies (or the absence of known allergies) were recorded.

Staff stored and managed all medicines and prescribing documents safely. Controlled drugs and medicines for emergency use were managed safely. Staff monitored the temperature of the medicine fridge and rooms where medicines were being stored.

However, when patients were administered oxygen, this was not always prescribed, or administration recorded.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The pharmacy team reconciled medicines in line with national guidelines. However, the trust was not currently meeting the trust target for the percentage of patients' medicines reconciled within 24 hours of admission.

Is the service effective?

Inspected but not rated

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Medical care (including older people's care)

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Board rounds took place daily which included all members of the multidisciplinary team (MDT) including physiotherapists, occupational therapists, nursing and medical staff. On the acute frailty assessment unit, a discharge co-ordinator from another ward supported the discharge pathway. However, there was no dedicated ward social worker to support elderly frail patient discharges.

On the medical assessment unit handovers occurred at key points during the day. These included nursing to nursing team handovers, pre-ward round handover, a post ward round multidisciplinary handover and an afternoon wrap around handover focusing on any cases of concern. Audit reports showed that in 2021 compliance in these meetings taking place had improved over the previous year.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff were able to refer to other specialities as required to enable patients to be supported in their community. For example, patients from the frailty unit could be referred to the community frailty nurses.

Staff referred patients for mental health assessments when they showed signs of mental ill health such as depression. Patient records showed that patients requiring mental health support were routinely referred to the mental health liaison team.

Patients had their care pathway reviewed by relevant consultants to ensure their care and treatment was effective. Records showed that patients had their needs assessed and treatment plans were co-ordinated to support their individual needs.

Seven-day services

Not all key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on their care pathway. There was a system in place for medical patients who were not on medical wards to be reviewed by medical staff from the outlier team.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The acute frailty assessment unit was open Monday to Friday for admissions from 7am to 5pm and was staffed by nursing staff 24 hours a day. This meant the frail elderly patients attending hospital at the weekend were not able to access the support of the unit and risked them requiring longer lengths of stay rather than the targeted intervention from the frailty unit.

The therapy team on the frailty and medical assessment unit were not available over a weekend to support existing frailty patients with their therapy needs.

Is the service caring?

Inspected but not rated

Medical care (including older people's care)

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We spoke with three patients and two relatives who told us they were happy with the care they received

Patients said staff treated them well and with kindness and respect.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. One patient reported that all care they received was good in relation to the physical and mental health needs being met.

However, we did observe one handover on the Nightingale hub that did not always preserve the dignity of patients. During the end of bed handover there was no patient interaction or eye contact. Patients were discussed openly in the bay including personal details such as toileting and feeding requirements. Staff were observed to refer to some patients more positively than others.

The department participated in the NHS Friends and Family Test (FFT) to gain feedback from patients and those close to them about care and treatment. Information provided did not give a location specific break down of the NHS Friends and Family Test.

Emotional support

Understanding and involvement of patients and those close to them

Staff supported patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us they had been involved in decision making and this included when they were going to be discharged. Records we reviewed also showed that discharge planning arrangements were in place.

Staff talked with patients and those close to them in a way they could understand.

Patients and those close to them could give feedback on the service and their treatment. Patients were asked to provide feedback to the ward regarding their treatment. Wards posted comments made by patients and actions that had been taken from complaints.

Staff supported patients to make advanced decisions about their care. Patient records showed that conversations had been documented with regards to any advanced decisions in care. These included consent to treatment and resuscitation following a cardiac arrest and discharge arrangements

Patients gave positive feedback about the service. The wards displayed feedback from patients and patients told us they were happy with the care and treatment they receive.

Medical care (including older people's care)

One patient who spoke positively about the care they had received was disappointed at the delay to be reviewed by the 'Home First' assessment team. They were told they would go to a care home until the assessment team could arrange the home assessment. (Home First enables the correct provision of the required short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means people no longer need to wait unnecessarily for assessments in hospital.)

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, due to pressure on bed capacity, there were times when patients were cared for in areas not designated for that purpose.

Facilities and premises were not always appropriate for the services being delivered. Due to the pressures for beds, the service required the opening of temporary beds to ease flow across the trust, or to provide treatment to patients on non-medical wards (outliers). This meant that care was not always being delivered to patients by the right ward speciality. Senior leaders worked to manage bed pressures, and this was on the trust risk register.

The trust had set a target that 80% of outlying patients would be reviewed daily by a consultant. This target was not achieved in January to April 2022. However, a snapshot audit conducted for the 5 April 2022, showed of the 35 patients classed as outliers, 94% had a senior review that day.

Patients on the Acute Frailty Assessment Unit and day case cardiac catheter suite when used as a surge ward did not have direct access to showering facilities. We did not see any breaches in the standards for mixed sex breaches. Staff had highlighted to the inspection team there had been mixed sex breaches on the Cardiac Catheter Suite when used as a surge ward. However, an audit report dated 13 April 2022 by the divisional nurse director reported there had been no mixed sex breach occurrences reported in the Cardiac Catheter Suite while used as an inpatient bed escalation area.

The service had systems to help staff care for patients in need of additional support or specialist intervention. The service had a variety of specialists including specialist nurses who were available to offer advice and support to staff and patients. For example, the service had access to a frailty specialist nurse to support the frail elderly patients and reduce their length of stay in hospital.

The medical care service had developed a frailty unit to support the frail elderly to return home quickly, avoiding lengthy hospital admissions which could exacerbate any long standing medical co-morbidities. However due to pressures for inpatient beds in urgent care this was not always used effectively for short stay frail elderly patients. This sometimes led to patients being on the ward for longer than 48 hours.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Medical care (including older people's care)

The service had systems in place to ensure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was a learning disability and mental health matron to lead a team of professionals to help support the wards to deliver a better patient experience.

We saw on some wards there was a campaign to promote the national 'end PJ (pyjama) paralysis' campaign (this encourages patients to get up, get dressed and get moving as they might at home). However, this was not promoted in all areas.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. This enabled the staff to learn more about caring for the patient. We saw that this was one of the commitments of improvement of the quality of care set out in the trust Dementia Strategy 2021-2024.

Wards were set up to meet the specific needs of patients. The service had a specific ward dedicated to the frail elderly and for rehabilitation. This ward was staffed by a multidisciplinary team to support a variety of patient needs and had equipment designed for the use of patients recovering from an illness. There were also specific wards designated for the care of other medical specialities.

The trust had a policy on meeting the information and communication needs of patients living with a disability or sensory loss. There was information on wards we visited that was available in easy read format to aid patients with communication difficulties.

The service was able to provide access to British Sign Language interpreters if needed, and the service had information leaflets available in languages spoken by the patients and local community.

Patients told us they were given a choice of food and drink to meet their preferences. Patients we spoke with reported the food was good.

Staff could access emergency mental health support 24 hours a day seven days a week for patients living with mental health problems, learning disabilities and dementia. There was a single call access for mental health referrals.

However, the Nightingale hub, which was used to temporarily increase inpatient beds, did not always meet individual needs. We observed most patients were in nightwear despite being optimised for discharge. The lack of natural day light or ability to distinguish between night and day could add to disorientation for susceptible patients. The trust told us there was heating, cooling and ventilation, controlled by a Building Management System (BMS) that kept the environment to comfort conditions and relevant air changes. However, it was reported that the environment could quickly become hot. There was a lack of activities available to patients with an activity trolley being brought out at a set time once a day in the morning. We observed and patients told us that they could not always access the day room with a television. However, staff told us that they did promote the use of the day room and the ward manager had ordered some clocks and radios for the bays. We observed that the day room was very cluttered with office equipment and seating was not positioned to be sat in. Other feedback was about noise at night-time especially from ambulances and the air helicopter. The average length of stay was 4.2 days on this unit. Patients are allowed three visitors per day in a one hour slot due to fire compliance restrictions.

Access and flow

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

Medical care (including older people's care)

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to minimise them. However, the hospital had ongoing capacity problems with available beds due to the high number of patients who were medically optimised for discharge (did not meet the criteria to reside). The number of medically optimised patients was calculated daily and distributed to managers to support discharge planning arrangements for patients. Data showed in April 2022 there were 107 patients who did not meet the criteria to reside.

The trust also calculated the number of bed days lost due to medically optimised patients occupying them. As at 24 March 2022, 523 bed days were lost due to medically fit patients not being able to leave hospital. This is however lower than data from January 2022 where 1107 bed days were lost due to medically optimised patients occupying beds.

Delayed discharges were impacted upon by the ability of care home providers to accept patients in the evenings and weekends which meant that patients had to stay in hospital longer. This was sometimes affected by discharge transport or discharge medication arriving after the care home cut off admission time. Additional impact on access and flow through the hospital was the long wait for patients to be assessed by a therapist for home first discharge and the availability of crisis hours to support patients on their arrival home until care packages could be implemented. There were also system wide shortages of social care beds due to outbreaks of COVID-19, staffing, and demand. Staff monitored the number of delayed discharges daily, to look at how these could be managed effectively. The trust had taken action to increase hours and therapists to improve access for home first discharge assessments. New system wide pathways were being developed to address the shortage of community support for patients ready to leave hospital.

There were many patients across the trust who did not meet the criteria to reside and were ready to leave hospital. These are known as super stranded patients. ‘Super stranded’ patients are those who have not met the criteria to reside for over 21 days. Across the trust the number of super stranded patients had been increasing since April 2020. In March 2022, the trust had 175 patients super stranded in hospital and did not require hospital services. In April 2020, the figure was 50. The immediate availability of care in the community meant that patients were not able to leave as soon as they were able to.

From March 2022 the rates of bed occupancy across the trust for those patients testing positive for COVID-19 increased from 4.4% in March 2022 to 14.8% in April 2022. This increased pressure on wards to admit, discharge and maintain infection control standards to ensure the disease was not transmitted.

Managers monitored waiting times and aimed to make sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in services it was not always possible to offer treatment within an agreed timeframe.

Managers worked to minimise the number of medical patients being cared for on non-medical wards (known as outliers). They were discussed daily at ward level and in senior managers’ meetings. While managers attempted to reduce the number of outlying patients this was made more challenging by the bed capacity pressures on the service. Managers had arrangements for medical staff to review any medical patients on non-medical wards and there was a medical team responsible for the care of outlying patients.

Managers and staff started discharge planning for patients as early as possible. The discharge planning for patients started once a patient was admitted to the hospital. Records showed, and patients informed us that discharge was discussed upon admission.

There were discharge co-ordinators on the wards to support the safe and structured discharge of patients to their own homes.

Medical care (including older people's care)

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Board rounds took place daily to discuss the next step in each patient journey on the ward. We saw that this included nursing, therapy, and medical staff.

There was one bed manager for medicine to support the flow of patients across the trust and ensure the right patient was placed into the right medical specialty bed. This was not always possible due to the number of patients requiring medical beds. Therefore, there were times when patients were cared for on wards that were not appropriate for their needs. For example, on the 5 April 2022 there were 35 patients who were not receiving care on a ward which specialised in the care they required. Staff also told us there was a lack of side rooms to accommodate patients who needed to isolate due to COVID-19 so could not be accommodated on the required ward. In addition, there was not always enough resources to facilitate timely bed moves.

In January 2022 the trust had increased bed capacity, by 50, with the temporary construction of the Nightingale hub. This was used for patients who were ready for discharge or stable and had a discharge plan in place.

At times of extreme bed pressures, the trust opened surge areas to cope with the demand for bed space. These surge areas had a standard operating procedure (SOP) to govern the process. The SOP detailed the purpose of these areas and any patients that should be excluded. On inspection we found the area to be operating within the SOP.

There was a discharge lounge to support the flow of discharges from the trust and freeing up bed space on the day of discharge. The trust had seen an increase in the use of the discharge lounge. In March 2021, more than 250 patients were discharged from the discharge lounge. In March 2022 this had increased to over 500 patients. Staff had implemented some initiatives to speed up the discharge process such as ensuring that take home medicines were prioritised for patients waiting to go home from the lounge. Wards were encouraged to identify one patient who could be discharged from the ward to the discharge lounge breakfast club by 8am, known as 'the golden discharge'. Despite this staff told us that the discharge lounge was not always fully utilised by all core services ensuring the timeliness of bed availability, especially at weekends.

Managers worked to minimise the number of medical patients on non-medical wards. However, due to ongoing bed capacity issues, patients were moved to another ward to make space for a patient who required a bed space on that ward. One patient told us they had been moved four times within a three week period.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. However, the trust did not consistently provide daily medical review for all patients from January to April 2022.

The ambulance service was able to directly refer patients into the Acute Frailty Assessment Unit. This reduced the need for the patient to be taken and seen by a clinician in the emergency department. However, this was dependant on the designated side room on the unit being available. The frailty unit had introduced a virtual ward to support patients discharged home to reduce readmittance through early interventions and liaison with community services.

Between October 2021 and March 2022, the medical assessment unit at the Royal Preston Hospital treated 3065 patients. Of these patients 2216 (72%) required staying on the ward overnight. The medical assessment unit could assess and treat patients so they could be discharged home the same day or moved to an appropriate medical bed. The medical assessment unit could admit patients overnight if required for up to 72 hours. Due to the high demand for medical beds patients were sometimes required to stay on the medical assessment unit for longer than 72hours until a suitable longer stay bed was available.

Medical care (including older people's care)

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The medical care service had a clear divisional structure with divisional committees feeding in information and evidence to manage divisional performance. These committees feed into the trust safety and quality division, and workforce committee.

The medicine division consisted of divisional medical director for medicine, divisional nurse director for medicine, divisional director for medicine. There was a clear senior management leadership structure. This was divided into two clinical business units acute services and long-term conditions across the trust's two sites.

There was a system and process in place to enable staff to be able to speak up about any safety concerns. There was a freedom to speak up policy and a freedom to speak up team. The freedom to speak up team received 408 contacts from staff across the trust in 2020/21 to raise concerns. This was up from 119 the previous year, 112 (30%) of which related to patient safety or quality of care. Although this was a percentage reduction over the last year it was still a significant numerical increase of 74 concerns.

There had been six whistleblowing incidents recorded. Five were reported to the CQC (Care Quality Commission). These related to safety standards relating to staffing levels, poor standards of care to patients, medicine administration and poor working environment.

Service performance reports were reviewed by the safety and quality committees, and up to the trust board to ensure the board had oversight of the divisional performance.

Although the trust was under pressure to care and treat patients and bed occupancy was high; staff we spoke with informed us they felt supported by their managers. In the 2021 NHS staff survey, 69.8% of staff agreed that their immediate manager encourages them at work.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The department and division recorded their risks on the risk register. Governance Meetings were held monthly where risks were reviewed and discussed. Items for escalation were reported into monthly divisional governance meetings.

Leaders in the service attended quality and performance meetings and contributed to them to improve the service. These meetings were well attended by directors and senior nursing staff.

Medical care (including older people's care)

Managers from the service took part in daily site meetings which had a focus on improving flow through the hospital where possible. These meetings were attended by colleagues from across the trust including the emergency department, meaning risks and resources could be discussed and shared across the trust.

The service had systems for recording, reviewing, and managing risks. We reviewed the departmental risk register and noted that it contained a description of the risk, a risk score, controls in place to mitigate the risk, any actions required and who had ownership of the actions.

The risk register was comprehensive and had been reviewed regularly. Risks on the register were identified at senior level such as the impact of shortages of staffing, bed availability and increased risk to patient care. They were clear and informed of the developments needed to improve quality and safety to patients and staff. Risks included where patient experience would be negatively impacted. For example, the use of trolley bays in escalation areas.

There were processes in place for senior leaders to stay informed with progress against all national and local audits. This in turn filtered down from committees to ward level. The clinical audit and effectiveness team reported to the quality and safety committee to provide an update and assurance on trust activity in relation to national and local audit activity and the trust position regarding the National Institute for Health and Care Excellence (NICE) Guidance assessment.

The senior management team were clear and informed of the improvements needed to reduce risk, issues, and improve performance to deliver better care for its patients. The trust had implemented several strategies, for example, the acute frailty unit had systems in place with the emergency department to assess patients suitable for direct assessment bypassing the emergency department. A side room on the acute frailty unit was kept for direct admission from an ambulance if triaged as suitable avoiding admission through the emergency department. A virtual frailty ward has also been established to avoid unnecessary admission through the emergency department with increased outreach support.

The trust had developed their bed escalation and surge plan. It was used alongside the operational pressures escalation level (OPEL) actions cards to ensure all actions, in addition to the escalation of beds, are taking place as appropriate across all areas. OPEL is a method used by the NHS to measure the stress, demand, and pressure a hospital is under. The plan set out the criteria for enacting this business continuity that included no in-patient and escalation beds available, long waits and limited space in the department. The Nightingale surge hospital was being utilised as part of the escalation process.

The medicine division also had a clinical service strategy. This was a three-year vision to return to a position of being exemplar of good practice, exceed national and local targets and provide excellent care with compassion.

These strategies were clear in scope and intent. However, not all strategies introduced addressed the significant access and flow issues which were impacting on patients and staff throughout the trust. For example, staff told us that initiatives were not always utilised effectively. Bed occupancy rates for the trust for 2022 were consistently above 90%. Occupancy above 85% can have a detrimental impact on providing high quality care for patients. The lack of beds had meant the opening of escalation and treating patients in non-medical beds. This meant patients were receiving treatment in areas outside of the medical speciality they need.

There were processes in place to review, improve, and share the trust strategies and objectives. In the 2021 NHS staff survey, 74% of staff who responded agreed that the team they worked in had a set of shared objectives which enabled staff to understand and better manage performance.

Medical care (including older people's care)

Areas for improvement

MUSTS

Medical care services

- The service must ensure there are systems and processes in place to safely prescribe, administer and record oxygen therapy. Regulation 12 (1)(2)(g)

SHOULDS

Medical care services

- The trust should consider the suitability of all areas of service facilities with regards to patient experience. (Regulation 10)
- The trust should ensure patients receive daily, timely review when not being provided care and treatment on the correct medical speciality ward.(Regulation 12)
- The trust should consider reviewing the effectiveness of some service strategies implemented across medical care services to address the fundamental access and flow issues.

Our inspection team

Our inspection team included an inspection manager, inspectors and specialist advisors.

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 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment